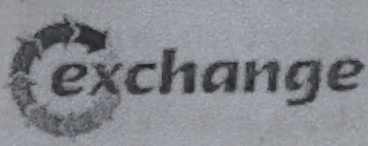
1283
PHM/SRG-54(RB4)
CPHE

Keeping the promise: The people's response to health for all

An evaluation report of the process that led to the People's Health Assembly 2000 and the development of the People's Health Movement

June 2004



'Primary Health Care was and still is the correct pathway for us all. Holding this meeting in East Africa is bringing the agenda home. Let's listen to these communities. How many times do we allow them to be part of their development? Genuine people-centred initiatives must be strengthened to increase pressure on decision-makers, governments and the private sector to ensure that the vision of Alma-Ata becomes a reality.'

- Dr. Upunda, Chief Medical Officer Ministry of Health, Tanzania, April 2002, opening a People's Health Movement workshop in Tanzania

'We are committed to health for all, to the strategy of primary health care, to health promotion, and to the reduction of inequities and social exclusion.'

- **Dr. Mirta Roses Periago, Director of the Pan American Health Organization (PAHO), January 2003**

'We must stop this co-option and define our own clear vision, sense of action and voice. … A key challenge for this Assembly is to organise into a global people's movement for health. We must be clear in our focus, clear in our purpose and clear in what we will and will not settle for. It must be a movement that recognises the political context in which it exists, that confronts and engages sources of power, that does not simply determine a shopping or priority list, but that demands not charity, but change.'

- **James Orbinski, Medecins sans Frontieres, PHA, December 2000**

'More than 50 per cent of the people in my country have virtually no access to health care. It's high time the public sector and the private sector focused on jointly providing health services to all sections of society.'

- **Dr Hugo Icu, Guatemala, January 2004**

'I believe in people. People's health is safest in people's hand. The objective is to empower individuals and communities with the knowledge and skills necessary to achieve health for themselves.'

- **Dr John Oommen, Orissa, India, May 2003**

'We call upon this assembly to globalise solidarity with the marginalized, to globalise our critical vision of the processes of health care reform that are being implemented, to globalise our experiences, and more fundamentally our proposals. Let us make this assembly an uncontrollable current of human solidarity, to move in a positive way towards a new consciousness and willingness until there is equity in health for our people.'

- **Dr. Violeta Menjivar, Member of Parliament, El Salvador, PHA, December 2000**

'I am here to show solidarity with fellow activists. There is a need to create a critical mass of people for changing the deteriorating health, social and gender situation.'

- **Dr. Mira Shiva, All-India Drug Action Network, PHA, December 2000**

Table of Contents

Acknowledgements i
Acronyms ii
Executive Summary 1
Primary Health Care and People's Right to Health: background to the PHM 5
What do we mean by evaluation? 6
Making a dream come true: planning the PHA 8
The Assembly: an historic public health event 15
Post-Assembly: building a movement 23
Conclusions 31

Boxes, Tables and Figures
Box 1: Mobilising in India 12
Box 2: The People's Charter for Health 18
Box 3: Voices of the people: challenging the World Bank 20
Box 4: PHA-Exchange: a mailing list to link the globe 25
Box 5: 'A revolution of hope': the view of the PHM from Latin America 26
Box 6: Indicators of change 31
Box 7: Two complementary processes: Interaction of IPHC and PHM 33

Table 1: Pre-Assembly preparation and planning meetings 9
Table 2: Countries represented at the PHA 16
Table 3: Meeting the project goals 31

Figure 1: Framework for the analytical process leading to the background documents and the People's Charter for Health 11

Appendices
1. Evaluation Terms of Reference
2. Project Logical Framework
3. Evaluation questionnaire
4. Report of Evaluation Meeting in Nicaragua
5. Report of Evaluation Meeting in Tanzania
6. List of documents reviewed
7. People's Charter for Health
8. Memories and echoes
9. Communication Matters!
10. Circles

Acknowledgements

This evaluation report would not have been possible to produce without the cooperation and valued contributions of hundreds of people around the world who have answered questions, taken part in workshops, focus groups and meetings, and shared their perspectives. We cannot possibly name them all, but our thanks go out to them for their contribution. While every effort has been made to get as broad an input into this report as possible, we have probably missed some individual perspectives, but hopefully, we have captured the breadth of the experience.

In particular, we need to acknowledge the involvement and input of the People's Health Movement (PHM) Secretariat over the past couple of years. Both Qasem Chowdhury and Ravi Narayan have been excellent in sharing their experience, knowledge, understanding, and the myriad of documents and reports that help to highlight the way the People's Health Assembly moved from a dream to a reality and the way the fledgling PHM began to grow.

Over the past three years, a team of people has been working on the evaluation process. This includes: Andrew Chetley, director of Exchange, team leader and the main author of the evaluation report; Cecilia Muxi from Uruguay who helped facilitate a focus group in London, a workshop in Switzerland and co-wrote the final report; Mwajuma Masaiganah, from Tanzania who coordinated input through a regional meeting in Africa and a workshop in Switzerland; Roberto Lopez, from Peru who coordinated input through a regional meeting in Latin America and co-facilitated the focus group in London; and Rebeca Zuniga from Nicaragua who helped facilitate a focus group meeting in London. This group was chosen in part because of their experience in working in and with international networks and movements as well as their skill and experience of using participatory evaluation methodologies as a learning process.

Our thanks also go out to the members of the PHM Steering Group who have reviewed the report and offered suggestions for improvements.

Evaluation team
London, June 2004

Acronyms

ACHAN	Asian Community Health Action Network
ART	anti-retroviral therapy
CI	Consumers International
CSI	Civil Society Initiative
DHF	Dag Hammarskjold Foundation
GK	Gonoshasthaya Kendra (People's Health Centre) Bangladesh
HAI	Health Action International
IPHC	International People's Health Council
PAHO	Pan American Health Organization
PHA	People's Health Assembly
PHC	Primary Health Care
PHM	People's Health Movement
TWN	Third World Network
WABA	World Alliance for Breastfeeding Action
WGNRR	Women's Global Network for Reproductive Rights
WHA	World Health Assembly
WHO	World Health Organization

Executive Summary

A global People's Health Movement (PHM) began to emerge in December 2000, when nearly 1500 people from over 90 countries met for five days in Savar, Bangladesh to re-establish health and equitable development as top priorities in local, national and international policy-making. In the intervening three and a half years from this initial People's Health Assembly (PHA), the movement has stumbled, struggled, and become stronger, and today is having an increasing impact on health policy and practice.

An indicator of the impact that PHM is now having comes from its interaction with the World Health Organisation. In December 2000, despite being invited at the highest level to attend the PHA, no one was officially representing the WHO. In January 2004, several representatives from the WHO attended the PHM activities around the World Social Forum in Mumbai, India and were requested by the Director-General's Office to explore closer engagement with the PHM.

Strong and ongoing activities have been taking place in Asia (particularly South Asia) and in Latin America. Within South-East Asia and the Pacific and the Middle East, events connected to the 25th anniversary of the AlmaAta declaration on primary health care were used during 2003 to help mobilise further action. Communication processes within the movement are improving and more attention is now being paid to building and developing strong and effective alliances and working relationships with other networks, movements and organisations.

The People's Charter for Health, elaborated through a worldwide consultative process and finalised and endorsed at the PHA, has been spontaneously translated into more than 40 local languages. This indicates the degree to which the Charter and its demands for social, political and economic change to improve health reflect and resonate with the reality of the situation facing the millions of people living in poverty.

Unique approach to social mobilisation

This People's Health Assembly – the first of its kind – was a unique social mobilisation exercise. In country after country, it involved people in village meetings, in district meetings, in national events, in regional workshops to prepare for the global gathering in Bangladesh.

Along the way, the voices of the people were heard:

- articulating their demands for better health, justice, peace and equity
- reaffirming their rights and responsibilities to be involved in the decisions that affect their lives and their health
- confirming that the right to health is one of the basic human rights to which they are entitled.

The five-day meeting in Bangladesh provided an opportunity for people involved in health, development, human rights, agriculture, trade and economics, the environment and many other fields to converge, to share ideas and continue a process of building a coalition to drive change.

Anyone who took part in the PHA describes it as a transformational process. It changed their lives. The challenge now is to see if the inspiration, solidarity and linkages that occurred can be sustained.

Evaluation and learning

This report is one output from a three-year participatory evaluation exercise that has helped to engage the PHM leadership in an analytical learning process based on ongoing experience. The evaluation has looked into the preparation of the PHA, the Assembly itself, and follow-up activities. Led by Exchange – a networking and learning programme on health communication – it has assessed the current status of PHM activities, explored ways to reinforce and enhance current accomplishments, and examined approaches to strengthen and sustain monitoring mechanisms.

A key feature of the PHA is that there was no real model for this type of exercise. There are many examples of international meetings, but few that feature a focus on people's voices or that start from local experience. There are countless examples of meetings where experts deliver papers, but few where testimonies of the daily realities of the impact of globalisation policies, poverty and illness drive the agenda and the search for solutions. This was uncharted territory. A significant outcome of the process is that it has begun to elaborate new models for organising, new approaches to giving voice to the vulnerable, and new ways to advocate for social change.

Planned achievements

The PHA process aimed to develop and endorse a People's Charter for Health and to achieve a further seven outputs:

- hearing the unheard
- re-enforcing the principle of health as a broad cross-cutting issue
- sharing and enhancing knowledge, skills, motivation and advocacy for change
- improving communication between concerned groups and institutions
- developing enhanced cooperation between concerned actors in the field
- enhancing media interest in health/equity issues
- increasing involvement of the poor in the dialogue process.

PHA participants surveyed feel strongly that the unheard did have an opportunity to be heard; that health was reinforced as a cross cutting issue and that skills and knowledge were shared during the Assembly itself. There was a less strong sense that communication between different groups and opportunities for enhanced cooperation happened. There was some uncertainty as to whether media interest was enhanced or to what degree the poor were really involved.

On balance, the overall impression of the Assembly itself from participants was that it was a unique, transforming experience. It had a profound impact on the 1500 people who attended, and nearly all of them have communicated with others about the experience in some way.

As a judge from India who attended said, 'The biggest achievement was making the world aware that the health of the common folk had to be a matter of international concern'.

On balance, the process that was set in motion to develop the PHA and get the event held was a positive one. It involved a number of organisations and networks, consulted widely on content issues, and reached out to a large audience to encourage involvement and participation. However, there were also difficulties: not least the overwhelming burn out and exhaustion of some of the organisers who faced severe stress in trying to cope with growing and unexpected numbers of participants. The sheer volume of people who attended meant that some of the carefully planned mechanisms to deal with debate and arrive at clear positions on many issues were not able to function. The issues were certainly raised and the problems articulated; clear expressions of possible solutions were not always reached. Many of the people involved in organising the event are highly critical of the outcomes.

A major failing of the process was the lack of a plan (and the resources – human and financial - to carry it out) about how to follow up the Assembly and maintain the enthusiasm and solidarity that was expressed. As a result, some of the dynamism of a new popular movement was initially lost. It was nearly a year after the PHA that the ideas for evolving a People's Health Movement that built on the first Assembly and began to work towards implementation of the demands in the People's Charter really began to develop.

In that sense, the words of a professor of medicine based in the UK have some relevance: 'It was a remarkable and memorable achievement, but now what?'. Those words are echoed by a representative from a civil society organisation in India who said, 'The idea was good. The implementation could have been better.'

Up until the beginning of 2003, any assessment of the efforts to move the PHM forward would have had little positive to say. Although a great deal of work was going on behind the scenes, little was visible on the ground, and where it was, it appeared patchy, sporadic and largely uncoordinated through 2001 and 2002. Through 2003 and into 2004, greater coherence is beginning to emerge.

A large factor in the slow follow up to the PHA lay in the lack of a clear strategic plan and a corresponding communication strategy to reach out to different audiences. More recently, planning processes have come into effect that are addressing this and beginning to develop strategic approaches and concentrate on improving internal and external communication.

Other issues that the PHM needs to address include:

- maintaining and growing the movement (including the dynamics of networking)
- leadership and governance.

Networking

There are enormous challenges in trying to maintain an effective network that combines a broad range of organisations and individuals. Networks, organisations, and individuals involved in the PHM work on a wide range of issues – from the very specific to the very broad – and at a number of levels – local, national, regional and international.

One of the strengths of the PHM was that it grew out of associations and links between people and groups working in a range of sectors - health, environment, education, agriculture, nutrition, trade, economics. Can the PHM continue to relate across these sectors and build strong links? It will need to if the movement is to remain relevant. A particular weak spot for the PHM is Africa. Few African participants attended the PHA and the scope for follow up has been limited.

Leadership and governance

Although there has been some discussion of possible structures (a series of interacting 'circles' or associations of people and organisations working on particular topics) to provide guidance and leadership for the PHM, there are still many unresolved issues. This is to be expected in what is a 'young movement'. However, an encouraging comment that emerged in the evaluation process is that it is a young movement 'with wisdom'. The PHM has its roots in a number of social movements in every part of the world. Within the PHM are a number of people, networks and organisations with long experience of international collaboration. If that wisdom is used to continue to clarify issues of leadership and governance over the coming months, and developing principles and guidelines for how important decisions are made, there is a strong likelihood that the PHM will continue to grow and increase its impact.

Primary Health Care and people's right to health: background to the development of the People's Health Movement

Throughout the 1960s and 1970s important efforts were underway to tackle the major causes of deaths and illness. Countries such as China, Tanzania, Sudan and Venezuela initiated successful programs to deliver basic and comprehensive programmes of Primary Health Care (PHC) covering poor populations.

The PHC approach put a conceptual framework in place and analysed and synthesised concepts to encourage fundamental changes in the delivery of health care services in developing countries with an emphasis on prevention and equity.

In 1978, 134 health ministers from around the world signed the Alma Ata declaration on Primary Health Care that set a deadline to achieve Health for All the people in the world by the year 2000. Access to basic health services was identified as a fundamental human right. And with that human right went the responsibility of people and communities to be involved in the design and implementation of better health care services that emphasised prevention.

This meant community participation in tackling the underlying causes of disease, such as poverty, illiteracy and poor sanitation. The roots of many health problems lie in the persistence of poverty and a continuing lack of effective health services.

PHC was successfully implemented in a few countries in different regions, but in most countries it was only rhetoric. PHC did not achieve its goals for several reasons, among which is the lack of political commitment including the refusal of policy makers and experts to accept the principle that communities can plan, manage and care for their own health. Policy changes including a new focus on health sector reform, and increasing reliance on global macro-economic models and a neo-liberal trade agenda have also contributed to diverting attention from comprehensive PHC approaches.

The lack of action by policy makers was obvious. A number of groups and organisations began to organise around this issue to raise the political will to commit to PHC in a sustainable way with a community-based approach.

For the last two decades, civil society involvement, commitment and action has increased at national, regional and international level, as a global effort to increase awareness and strengthen comprehensive health strategies built in local communities.

In the mid 1980s, many of those groups began to talk about the need for a people's assembly to discuss health issues and explore the way forward. Nearly 15 years later, those early dreams of a way to bring grassroots experience and reality to the policy debate became a reality with the holding of the first People's Health Assembly (PHA) in Bangladesh in December 2000.

This report tracks some of the pathways that led up to the event, looks at what happened during the PHA, and begins to trace some of the developments that have happened since, including the development of a new People's Health Movement (PHM) that is starting to have a global impact.

What do we mean by evaluation?

In this document, evaluation is taken to mean *an analytical process that seeks to learn from and understand the experience that it is investigating.*

Within that process, two complementary approaches were taken. One approach was to look at the activities leading up to the People's Health Assembly (PHA) and the Assembly itself and the other approach was to look at efforts underway to develop follow up activities and begin to develop a People's Health Movement (PHM).

Both approaches offered opportunities to document the activities that are being undertaken, to reflect upon them in a participatory manner, to identify lessons, to feed those lessons into ongoing activity and to identify ways of sharing those lessons more widely among organisations doing similar work. Although the PHA was in many ways a unique event, it is a form of social mobilisation that occurs at other scales within the health and other sectors. Valuable lessons can therefore be used to improve effectiveness of social mobilisation and advocacy activities elsewhere.

What's being evaluated?

The logical framework for the main project proposal around the PHA sets out a series of outputs and measurable indicators that we have used to assess progress (see Appendix 2). There are also less quantifiable indicators that emerge from a communication perspective that were used by the evaluation team and by people involved in the PHA process to help reflect on each of these outputs and assist in the learning process. In addition, as one of the outcomes of the PHA itself was the emergence of a fledgling People's Health Movement, we applied some of these same questions and principles to the development of the movement.

The 7 identified outputs are:

- hearing the unheard
- re-enforcement of the principle of health as a broad cross-cutting issue
- formulation and endorsement of a People's Charter for Health
- sharing and enhancement of knowledge, skills, and advocacy for change
- improvement of the communication between concerned groups and institutions
- development of enhanced cooperation between concerned actors in the field
- enhanced media interest in health/equity issues.

The broader indicators include:

- What (if any) increase has there been in public and private dialogue and debate around the key issues highlighted as part of the PHA process?
- Has the accuracy of the information people share in the dialogue increased?
- To what extent were the people centrally affected able to voice their perspective in the dialogue and debate? (Which groups are most disadvantaged? How were they supported to voice their views? What happened?)
- Has there been an increased leadership role by people who are disadvantaged? Who made the major decisions about the planning and operation of the PHA? How were people centrally affected engaged in the decision making process? Any example where the involvement has led to changes in strategy or fine tuning?

- To what degree does the debate and discussion resonate with people's everyday issues? what issues provide the focus? How were people energised/mobilised by these issues? What actions followed?
- Has it linked people or organisations that might not otherwise have been linked? Which groups? What are their interests? How linked? Has an alliance been formed? How does it work?

In terms of the follow up, and development of the PHM, the evaluation has considered:

- Has there been enhanced cooperation among key individuals and organisations active in public health?
- Have people most at risk from poor health conditions played an active and central role in the planning, development, leadership and governance of the PHM?
- Has the PHM enabled dialogue and discussion at various levels and in different arenas to encourage change in policies and practices affecting people's health?
- Has the PHM evolved effective internal and external communication strategies to ensure active participation, inclusion and impact?
- Is the PHM an appropriate platform for facilitating the voices of the unheard to be heard?

Methodology and timeline

Exchange was approached to develop an evaluation process before the PHA. Initial planning for the process took place between January and August 2001, including the development of an initial report of the PHA.

The evaluation process has used a combination of techniques and tools and a variety of sources and informants to ensure a reflective process that enabled the diversity of the PHA participants and their goals to be expressed. The evaluation team reviewed all available documentation about the PHA process globally as well as available information on some regional and national preparations. (Appendix 6) Structured, semi-structured and open-ended interview techniques were used to elicit feedback from participants, organising group members, media, and other interested stakeholders (such as the donor community). A simple and easy to complete questionnaire (see Appendix 3) was sent to all identifiable participants during 2002 and the findings analysed in late 2002. Regional focus group sessions and reflection workshops were held with participants from two regions of the world (Africa in May 2002 and Latin America in December 2001) to enable those whose voices are not usually heard to play a key role in the evaluation.(Appendix 4 and 5) . An international reflection workshop and an international focus group exercise were held in May 2003. Participant observation during a series of PHM organising group planning meetings between 2001 and 2003 has also informed the process. As an additional process, in May 2003, members of the International People's Health Council (IPHC) – one of the original partners in the PHA process – agreed a complementary evaluation process of their own activities that has helped to provide insight into the relationship between IPHC and PHM. Between May 2003 and May 2004, work has continued on organising, systematising and digesting the information from all these sources to enable it to be presented concisely.

Making a dream come true: preparing the PHA

In 1985, many of the people and organisations involved in Health Action International (HAI) – a network that encourages the rational use of drugs – began to talk about the need for more reality to be injected into the international policy process. The idea and the dream of a people-led assembly to discuss issues relating to health were born.

However, it was not until the late 1990s that the dream began to become more of a reality. In May 1998, a group of people from civil society organisations who were in Geneva for the annual World Health Assembly (WHA), picked up the germ of this idea and agreed to explore it in more depth. The year 2000 was around the corner. The dream of Health for All by 2000 was fading fast. The experience of nearly 30 years of participatory effort by communities, health workers, and a number of dedicated organisations to improve health at the grassroots, using Primary Health Care as the focus was under threat from new economics-led ideologies.

A meeting was called for Penang, Malaysia in November 1998 that was the jumping off point for the development of the People's Health Assembly. It involved a number of representatives from networks and organisations from Asia, Africa, Europe, and Latin America. Ultimately, an international organising group was formed that was instrumental in making the PHA happen. This drew upon the skills of the following networks and organisations:

- Asian Community Health Action Network (ACHAN)
- Consumers International (CI)
- Dag Hammarskjold Foundation (DHF)
- Gonoshasthaya Kendra (GK)
- Health Action International (HAI)
- International People's Health Council (IPHC)
- Third World Network (TWN)
- Women's Global Network for Reproductive Rights (WGNRR).

The organising group held a series of planning meetings between 1998 and July 2000. Other groups and individuals were also brought on board at the meetings to add particular skills, expertise or to represent key stakeholders in the process. Highlights of the main issues dealt with in those meetings and the principal outcomes are shown in Table 1.

The group of people who first gathered in November 1998 knew each other and came with their own ideas and thinking about what was possible. Much of the discussion at this point was on a conceptual level rather than looking at issues of organising an event. However a clear plan did emerge at that first meeting. It described an assembly of about 500 people that would listen to the voices of the unheard, be underpinned by the development of clear analytical perspectives of the situation and the way forward that could be discussed and enhanced in workshops, and the preparation and adoption of a Charter for People's Health.

Tensions began to develop as the issues around how to implement the process became more important. The first planning meeting identified some working groups to undertake key tasks. These included an analytical group, a fundraising group and the

beginnings of a logistics group. At the same time, many of the networks confirmed that they were prepared to help mobilise local and regional activity and support to lead up to the main event in Bangladesh, which was confirmed as the venue at the second planning meeting.

Table 1: Pre-Assembly preparation and planning meetings

MEETING	FOCUS	LESSONS LEARNED	DIFFICULTIES	POINTS MADE	OUTCOMES
First Planning Meeting 5–9 Nov 1998 Penang, Malaysia	☑ Concepts ☑ Ideas ☑ Content ☑ Criteria ☑ Particpants ☑ Allies	☑ Working on a people centered approach ☑ Need of some structure for decision making process	☑ Regional / overseas organization, development ☑ Need to be democratic	☑ Need to prioritise ☑ Political more important than social side ☑ What do we do?	☑ Initial format for the Assembly ☑ Working groups formed
Second Planning Meeting 2–4Mar1999 Penang, Malaysia	☑ Financial implications ☑ Development of Project Proposal ☑ Participatory process ☑ Need for Application	☑ Development of vision, goals , logical framework ☑ Purpose of the PHA clearly stated ☑ Strong involvement of fundraising orgs.	☑ Overwhelming nature of the task	☑ Gather people: to do what? ☑ Lot of work/things to assume and do	☑ Venue decided ☑ Dissemination of project proposal
Third Planning Meeting 4–7 Sep 1999 Savar, Bangladesh	☑ Criteria for selection of participants ☑ Organizational management ☑ Working principles ☑ Topic Groups	☑ Pay attention to dates/link with partners events ☑ Clear working principles ☑ Improve internal communication process ☑ Be inclusive to increase ownership	☑ Different rules on pay/no pay work people ☑ Secretariat to move to Bangladesh ☑ Need for feedback	☑ Decisions on contracted versus volunteer work ☑ Not enough communication ☑ Logistics overwhelming ☑ Analytical work needs strong basis	☑ Brochure developed ☑ Budget revised
Fourth Planning Meeting 10–13 Mar 2000 Penang, Malaysia	☑ Logistics ☑ Secretariat management ☑ Preparations meetings ☑ Regional planning ☑ Position papers	☑ Need to establish clear principles and rules of work ☑ Decision making process ☑ mechanisms in place and communicated	☑ Analytical group vs mobilization group/ unbalanced ☑ Working group emerging system	☑ Need for balance of activities ☑ Overwhelming aspect of logistics ☑ ACTIONS vs. ANALYSIS	☑ Decisions of who does what ☑ Timeframes ☑ Process for developing Charter
Fifth Planning Meeting July 2000 Penang, Malaysia	☑ Logistics ☑ Secretariat management	☑ Need for a more fluent and open dialogue: analytical group experts and groups being mobilized	☑ Complementary strategic thinking	☑ Many different initiatives/ activities in place ☑ Mobilization experience different than diversity	☑ Need to revise Charter
Sixth Planning Meeting did NOT take place		☑ Missed opportunity to wrap up the PHA Event as a whole	☑ Organization ☑ PHA management ☑ Planning Coordination mechanisms in place	☑ Lack of funds	

From then on, the different working groups tended to drive the agenda forward – sometimes in directions that exacerbated tensions. The analytical process, including the development of background papers and the preparation of an initial draft for a people's charter, had one set of demands and deadlines. The logistics process was becoming increasingly complex as the numbers of people likely to attend changed and the possible venue was not finalised. The fundraising group had a difficult task in trying to ensure that sufficient funds were available to enable the PHA to definitely go ahead, while at the same time encouraging local organisations to mobilise their own resources to attend. Mobilisation of local people and organisations led to increased expectations that they would be invited to the PHA.

And with diverse types of people being involved in the development of the PHA, different ideas began to emerge about the purpose of the PHA. Was it, as some thought, an opportunity to demonstrate that people could come together and do a better job of debating serious health problems and coming up with workable solutions than was currently being done by health ministers and other government officials in the World Health Assemblies hosted by the World Health Organisation (WHO)? Was it an opportunity, as some thought, to inject some practical reality into the debate by enabling local voices to be heard and the stories profiled of how poor people coped with trying to stay healthy in an increasingly unhealthy world? Was it, as some thought, a chance to let off steam, to demonstrate, to shout, to protest about rights that were not being met? Was it a chance, as some people thought, to share experiences and ideas, to learn from each other, to explore ideas and make some links? Was it a chance, as some people thought to demonstrate solidarity with others in a common cause and to advocate for change? A stated characteristic of the PHA was that it was 'a long term process', but it was never spelled out clearly for what.

Juggling those different perspectives, the different demands and the different time frames and tensions was a difficult task for the organising group. Some people had done extraordinary things at a national level, some at a regional level, but there were fewer people involved in the organising group who had experience of working in international organisations and did not have a perspective on working at an international level.

Generally, what worked well was the development of the background materials, the information materials about the Assembly and the process of notifying large numbers of people about the event.

The analytical process had a clear framework and timetable. Figure 1 illustrates the analytical process and its interplay with the other parts of the pre-assembly process. However, there was not a corresponding framework and timetable for the Assembly event and follow up process as a whole. Instead, the analytical process tended to drive the planning. This may well have meant that some of the other elements – such as the national or regional work, or the logistics for the Assembly itself – did not get as much attention.

Activities leading up the PHA focused on three broad areas:

- **Analytical work** to develop a broad analysis of the major health issues facing the world, in order to provide a solid basis for policy formulation, advocacy and

development of innovative solutions. This drew on existing analyses and data as well as some original research by resource persons with recognised expertise. This background documentation guided discussions within countries and regions.

- **Country and regional meetings** to deepen understanding of and elaborate strategies to address priority health problems. These meetings aimed to:
  - bring together large numbers of health and development workers, community members and decision-makers
  - engage critically with the background materials
  - form a basis for future health development action.

- **Case studies, experiences and 'people's stories'** from a large number of countries were collected. These described people's direct experiences of health and health problems, their own analysis of causal factors, their initiatives, examples of success stories, failures and proposals for the future.

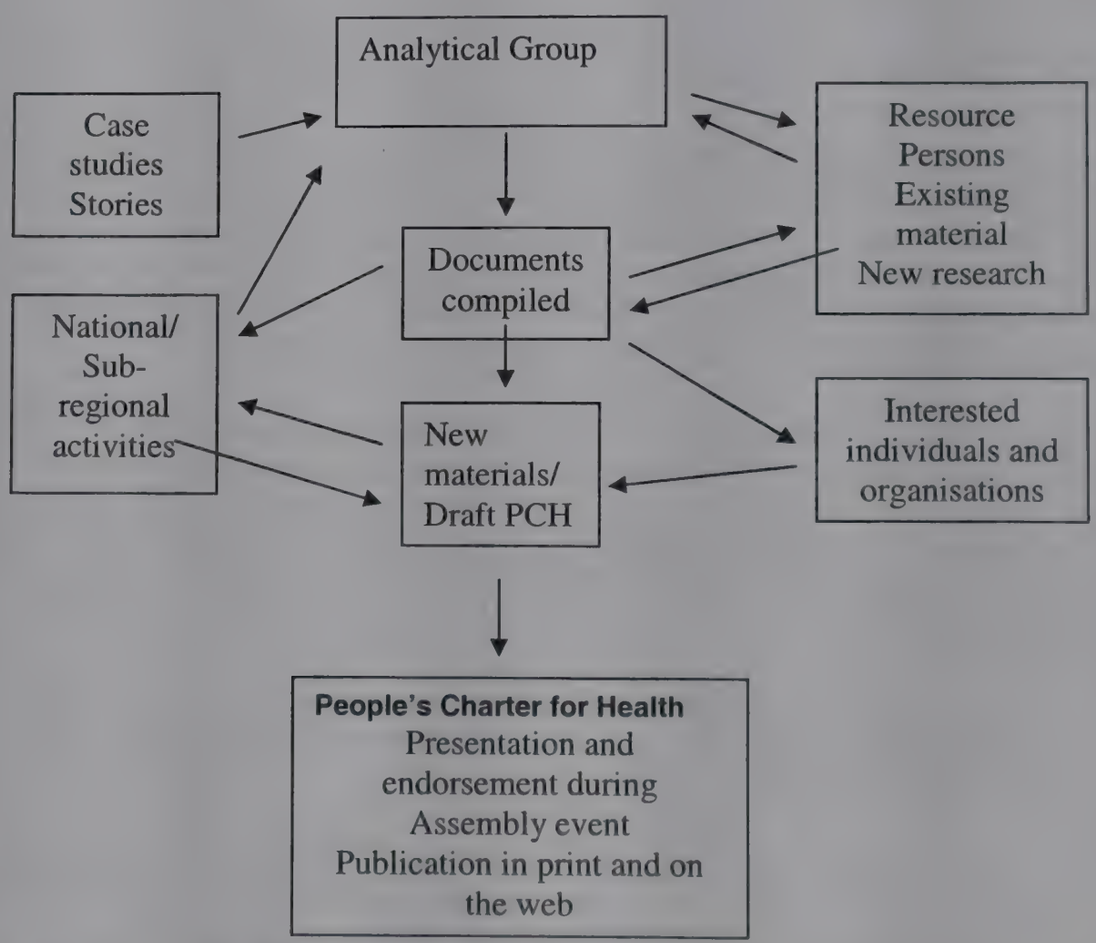

Analytical Group
Case studies Stories
Resource Persons Existing material New research
Documents compiled
National/ Sub-regional activities
New materials/ Draft PCH
Interested individuals and organisations
People's Charter for Health
Presentation and endorsement during Assembly event
Publication in print and on the web

Figure 1: Framework for the analytical process leading to the background documents and the People's Charter for Health

The attempts at mobilisation and developing pre-Assembly events at a local level varied according to the region. Throughout South Asia, there was considerable mobilisation. The example of India, in Box 1, is one of the most thoroughly documented.

Box 1: Mobilising in India

Amruta S.V. rode a train for four days as it made its way across southern and eastern India before reaching Calcutta, according to an IPS report by Sandhya Srinivasan.

This was no ordinary train journey as all the passengers went to Calcutta to attend a unique gathering of public health activists and people's groups from across the subcontinent. It was one of four 'people's health trains' that started from the southern, western, northern and north-eastern corners of India.

The slow-moving trains picked up their passengers from all over India. 'We would get off at the stops to shout slogans and sing songs along the way,' said Amruta from Mahila Samakhya, a women's group in southern Karnataka state.

More than 20,000 people like her, from all over India, were in Calcutta for the 'Indian Health Parliament' that was being held ahead of the global People's Health Assembly (PHA) in Bangladesh from 4-8 December 2000. People from all walks of life - village health workers, doctors, activists, government officials, researchers, policy makers, political leaders, voluntary organisations, peoples' movements and journalists - came together. The Calcutta meeting was the culmination of several months of work, which involved some 1,000 groups, 18 national networks and generated the enthusiasm and participation of a broad cross-section of people. Only 8 of the 18 national networks were focused on health. This meant a move away from the usual bio-medical focus around health work.

An example of the way the process worked comes from this Times of India article of 8 November 2000 on how NGOs were organising to demand more spending on health:

"The heavy downpour on Sunday evening did not deter more than 200 people from attending a rally organised to demand accountability from civic and health services, and the regulation of services by private doctors and fair price shops. The rally was organised by two Non-Government Organisations, Ashish Gram Rachna Trust (AGRT) and Arogya Vikas Samanway Samiti (AVSS), on Sunday evening. Calling it the 'March for health', the participants started from two points in the Mundhwa-Ghorpadi slums, and converged at the Jai Hind Chowk, Ghorpadigoan, where a meeting was held. Residents of the slums also attended the meeting ... which was addressed by the chief guest of the function and representative of the People's Health Assembly, Datta Desai."

Six major background papers and a draft People's Charter for Health were discussed in depth in all the states and in at least 100 of India's districts. The Calcutta meeting approved a national People's Health Charter. After Calcutta, more than 200 people boarded buses and set off on the next leg of the journey, to the Assembly in Bangladesh to carry forward their demand for the implementation of health for all in South Asia and around the world.

Ravi Narayan, currently the international coordinator for the People's Health Movement, says that the mobilisation activities in India increased the interaction among a large number of civil society organisations and networks. 'Many of us had worked together, but not this deeply.'

The best regional mobilisation took place in Latin America, where a strong regional network of health workers and organisations active in community health already

existed. In Africa, there was little or no mobilisation. By the March 2000 planning meeting, it was clear that differences in approaches on the ground were occurring. Regional coordinators had been identified largely on the basis of their interest, rather than their ability to network and mobilise. However, there was little time and few resources to improve the situation.

Initial planning suggested that some 500 people would come to the Assembly. As late as March 2000, the planning was centred on no more than 600. As time passed, it became clear that those numbers were increasing. By September 2000, the Secretariat knew it was well above 800 and rising fast. There was no clear way of identifying who or how many people could come.

In the end, the analytical work was excellent, although not widely used in the PHA itself (nor subsequently). The country and regional activities were poorly coordinated, patchy and variable. They ranged from tremendous and extremely participatory to poor and virtually non-existent. The collection and use of the case studies and stories was limited. Some found their way into the PHA plenaries. Few were documented, however.

As one participant who was commenting on the PHA itself said: 'The idea was good; the implementation could have been better.' The same could be said about the pre-Assembly process.

Lessons learned

The PHA and the long-term process towards the PHM demanded very careful planning. Although there was some understanding of the complexity of organising the PHA, the event went beyond everyone's expectations and also most people's experience.

In spite of the nearly two years of important planning and the five meetings leading up to the PHA, several aspects of the Assembly did not function as expected. Undertaking such an event in the future demands that more attention is paid to several key issues. These include:

- clear identification of the **purpose** of the event: the PHA in Bangladesh had several, sometimes conflicting, purposes. As a result, its main impact was on those who attended and many participants described it as a transformative moment in their own lives. Maximising and extending that impact to others requires much more attention in any future events.
- a well developed **planning process and framework** that sets out the working principles, activities and tasks and identifies those responsible in carrying out specific action and the timeline by which it needs to be completed. This needs to be communicated clearly to everyone involved and can serve to integrate the work carried out by any specific working groups. These are likely to be: :
    - funding group
    - policy/analytical/content planning group
    - logistics/secretariat group
    - documentation team (see separate point below)
    - follow up team (see separate point below)
    - evaluation group.

- ensuring a **documentation** team is established that takes responsibility for effectively documenting the entire event, and that communication strategies for sharing the outputs, including maximising media interest, are in place
- having a planning group to focus exclusively on **follow up** and to support participants in disseminating the learning from the event and advocating for further action in their own locations. Such a group also takes on the responsibility for organising the process of deciding how to implement any of the action points that emerge in the event
- **mobilising sufficient resources** (through adequate and timely funding proposals or in-kind committed contributions) to cover the essential elements for the event, including an effective monitoring and evaluation process.

Planning for an Assembly like the one held in 2000 involves a large number of people, groups, organisations and networks – many of which hold different perspectives on what needs to be done. The planning process itself is a highly complex activity. Sufficient time and resources, both financial and human, need to be dedicated to the planning process.

An advantage of any future PHA is that is should emerge from the strategic planning processes of the PHM. This may make it easier to resolve some of the problems that the organisers of the first PHA faced.

The Assembly: an historic public health event

Events and dialogue processes in more than 100 countries preceded the PHA in Bangladesh in December 2000. The PHA itself was described by Dr Qasem Chowdhury, Coordinator of the Secretariat for the PHA, as 'a small step but one that has involved literally millions across the globe in the overall process'. He said the gathering defined a moment in the history of public health – one where the problems of the previous century were still with us and the problems of the new century are now looming large.

This historic event was the result of years of hard and determined work by many. It was the product of the collective energy and effort of health activists from all around the world. Thousands of people coming from village meetings, district level workshops and national gatherings were integral to the preparatory process for the Assembly. Each of them was encouraged to carry on with the responsibility to take back the resolutions and spirit from this Assembly to the communities from which they came.

The goal of the PHA process and the Assembly itself was to strengthen the linkages among people and build an international health movement where the goals of Health for All will regain its rightful place on the development agenda, and the achievement of this goal will be pursued with renewed vigour and commitment.

The theme of the Assembly was "to hear the unheard". It brought together nearly 1500 people from 93 countries. The majority of them came from countries in the South. (Table 2 below lists most of the countries represented.) And a large number of them came from grassroots organisations or organisations that work closely with poor and marginalised communities.

However, the meeting in Bangladesh – as impressive as it was to bring together such a diverse, multinational group of organisations and people – was not the end point. It was meant to stimulate continued action that could carry forward the momentum generated by the preparation and by the Assembly itself, and to strengthen networking among the participating individuals and organisations.

The Assembly itself was designed to be as participatory as possible and to involve a large number of people and stakeholder groups in the preparations. Assembly activities included keynote addresses, analytical presentations, sharing of people's testimonies and stories on health practices and concerns, workshops, debates, cultural and audio-visual presentations and exhibitions.

> ***'The Assembly provided an opportunity for all of us to listen to those voices and to become one with their struggles. The declaration of the Charter will be but one step in making these voices heard by policy makers, governments and international organisations.'***
> **- Dr Qasem Chowdhury, Gonoshashaya Kendra, Bangladesh**

Each day of the Assembly began with a cultural activity or an opportunity for solidarity announcements, followed by a plenary session. At this time, participants had the opportunity to present their direct experiences clearly, directly and movingly.

Table 2: Countries represented at the People's Health Assembly

Afghanistan	Dominican Republic	Japan	Nicaragua	Sudan
Argentina	Ecuador	Jordan	Nigeria	Sweden
Armenia	Egypt	Kenya	Norway	Switzerland
Australia	El Salvador	Lebanon	Pakistan	Syria
Bahrain	Fiji	Liberia	Palau	Tanzania
Bangladesh	Finland	Malawi	Palestine	Thailand
Belgium	France	Malaysia	Panama	Tunisia
Benin	Gambia	Mali	Philippines	Turkey
Bolivia	Germany	Mauritius	Russia	Uganda
Brazil	Ghana	Mexico	South Africa	Ukraine
Cambodia	Greece	Moldova	South Korea	United Kingdom
Cameroon	Guatemala	Morocco	Samoa	United States of America
Canada	Hong Kong	Mozambique	Saudi Arabia	Vietnam
Chile	India	Myanmar	Senegal	Yemen
China	Indonesia	Namibia	Seychelles	Zambia
Congo	Iran	Nepal	Sierra Leone	Zimbabwe
Cuba	Iraq	Netherlands	Singapore	
Denmark	Italy	New Zealand	Sri Lanka	

Each day had an overall theme:

- health, life and well-being
- inequality, poverty and health
- health care and health services
- environment and survival
- ways forward.

Each afternoon, some 15-20 concurrent workshops were held. Through these a broad range of topics and issues were discussed and explored and a number of ideas and plans for taking work forward emerged.

Two workshops on each of the first four days were developed and managed by the PHA organising group. One dealt with the discussion of the PHA issue paper that underpinned the day's theme. The second workshop provided an opportunity to discuss the People's Charter for Health.

The overall aim was to move towards the development of action plans on the last day.

> ***'As far as the objective of "hearing the unheard", the PHA was very successful. It was centred on people, people were doing most of the talking, the trial was held by them and it was their verdict.'***
> **- Andrew Chapfika, Zimbabwe**

Reflections about the Assembly

Five simple questions have been used by the evaluation team to stimulate reflection and dialogue in the various workshops, events and interviews to explore what happened during the PHA. These were:

- What was significant?
- What worked well?
- What was less good?
- What would have made it better?
- Was anything missing?

Significant outcomes included:

- the extraordinary number and variety of people attending
- that it happened at all
- the large number of participants from grassroots organisations (many of whom had never been out of their country and in some cases their village before)
- the development of a people's charter for health (see Box 2)
- stimulation of a global health movement
- confirmation, as one Latin American participant expressed it, that 'the path we have chose to follow, although hard, is the right one'
- positive impact on the people involved with the Gonoshasthaya Kendra programme in Bangladesh
- a strong sense that health was 'rescued' as a fundamental right of the people, both collective and individual.

'It was a really wonderful process. I never thought very seriously about the connection between inequality and health issues, but I have learned a lot in the past five days.'
- Sri Rahayu, Indonesia

'I thought PHA 2000 was fantastic. We could do a lot of networking and establish contacts across sectors. Sometimes when you are on our own, you think there are only a few people who don't agree with the direction the world is going in. It is good to know that there are so many people who think like you.'
- **Fran Baum of Australia**

For many people, the most significant event during the PHA was the session with the World Bank. Richard Lee Skolnik, Regional Director for Health, Nutrition and Population for South Asia at the World Bank was invited to 'meet the people'. His session started with a strong protest from the 200-strong Indian delegates that the Bank's policies were harming development prospects for the poor. Speakers from Guatemala and Zimbabwe set the scene in terms of the impact Bank policies had on the poor in their countries. Richard Skolnik responded with an admission that some past policies had not worked, but said the Bank was learning and now he was offering a partnership between the World Bank and the People's Health Assembly.

His speech came in for immediate and cutting rebuttals from people from the Philippines, Australia, Zimbabwe and Bangladesh. The session ran well over time. But there was no doubt that it was a turning point. It focused attention on many of the critical issues and on the need to see the answers to the health of poor people not simply in tending to the diseases of poverty – such as malaria, TB, HIV/AIDS – but in paying attention to the broader determinants of health – including the inequitable

global trading and financial systems. It was also a clear demonstration of the power of the voices of the people (see Box 3).

Box 2: The People's Charter for Health

A big success of the Assembly was the Charter and the participatory process to build and endorse such a document for action. Each aspect was considered and explored in detail.

The People's Charter for Health presents a set of concerns and vision for the future that can be used as a rallying point in the struggle for better health, social justice and equity.

When Nadine Gasman from Mexico - who was the member of the Organising Group responsible for overseeing the Charter process – introduced the concept to the Assembly on the first day, she described the Charter as both a 'vision of hope for the future' and as a political document.

The Charter was developed over nearly 18 months and involved a first consultation to identify the key guiding principles, concerns and possible areas for action. This led to an outline draft that was circulated to a wide range of organisations around the world for suggestions and input.

The first draft of the Charter was widely discussed at regional and national meetings in all parts of the world. It also led to the development of local versions: in India, Nepal and Central America, for example.

Through this process, a number of suggestions were incorporated into the basic draft Charter. Over the first four days of the Assembly, participants were able to take part in a daily workshop to review the Charter and to offer improvements. A large number of boxes were also distributed around the Assembly site to enable people to contribute written suggestions. Several hundred suggestions were collected. A drafting team, headed by Nadine Gasman, met each day to consider and discuss the issues. Where any issue emerged that the drafting group felt needed additional input, it was brought to the attention of the daily meeting of the Organising Group.

Final drafting took place through the third and fourth day and well into the fourth night of the Assembly. The Assembly Secretariat laid out the final version and staff at the printing press at Gonoshasthaya Kendra worked through the night to have printed copies available early on the final day for people to have in their hands. Shortly before lunch, an international group – representing Latin America, Europe, Asia, and Africa read out the Charter for the Assembly. At its conclusion, there was spontaneous approval and participants signed banners and printed lists confirming either their personal or institutional endorsement for the Charter.

Key points

The full Charter is contained in Appendix 7. It builds on five basic principles – one for each of the five fingers in the hand holding the globe in the PHA logo. These are:

- The attainment of the highest possible level of health and well-being is a fundamental human right, regardless of a person's colour, ethnic background, religion, gender, age, abilities, sexual orientation or class.
- The principles of universal, comprehensive Primary Health Care (PHC), envisioned in the 1978 Alma Ata Declaration, should be the basis for formulating

policies related to health. Now more than ever an equitable, participatory and intersectoral approach to health and health care is needed.
- Governments have a fundamental responsibility to ensure universal access to quality health care, education and other social services according to people's needs, not according to their ability to pay.
- The participation of people and people's organisations is essential to the formulation, implementation and evaluation of all health and social policies and programmes.
- Health is primarily determined by the political, economic, social and physical environment and should, along with equity and sustainable development, be a top priority in local, national and international policy-making.

Following on from these principles, the Charter sets out key demands on the issues of:
- health as a human right
- tackling the broader determinants of health
- a people-centred health sector
- people's participation for a health world.

Examples of those demands include
- press governments and international organisations to reformulate, implement and enforce policies and practices which respect the right to health
- transform the global trading system including effective regulation of transnational corporations
- cancel Third World debt
- transform the global financial system, the UN system and the WHO
- place education and health at the top of the political agenda
- ensure universal human rights
- ensure health and environment impact assessments are incorporated into development activities
- end the use of occupation and sanctions, and support campaigns and movements for peace and disarmament
- oppose policies that privatise health care and turn it into a commodity
- demand that governments promote, finance and provide comprehensive primary health care
- promote, support and engage in activities that encourage people's involvement in decision making
- ensure people's organisations are represented in local, national and international fora that are relevant to health.

'It was very important to have a meeting like this. The People's Charter for Health is an important tool and should be followed carefully to evolve plans for action.'
- Hani Serag, Egypt

During the assembly itself participants have indicated that they feel strongly that the unheard did have an opportunity to be heard; that health was reinforced as a cross cutting issue and that skills and knowledge were shared. There was a less strong sense that communication between different groups and opportunities for enhanced cooperation had happened. There was some doubt as to whether media interest had been enhanced or whether the poor were really involved.

Box 3: Voices of the people: challenging the World Bank

The World Bank session closed with a series of people's voices from around the world, reflecting on their personal experience of what they had heard and what they knew of the reality of the World Bank's impact.

'They come in sheep's clothes, like a tidal wave to submerge our countries,' said a voice from the Pacific.

'We need to eliminate global poverty. We do not want to become a region of healthy poor. Such a thing does not exist. Millions and millions of people are being exploited by globalisation,' said a voice from El Salvador.

'I cannot ignore the depth of concern I have heard in the audience,' said a voice from the United Kingdom.

'Our people are dying every day. Our children can't go to school. These restructuring programmes should go. It hurts as a mother to have a child who has to service a debt that was there when the child was born,' said a voice from Zambia.

'The Bank can be bankrupt, if we target the biggest shareholder,' said a voice from the Middle East.

'We spoke our hearts, because this is our cause. We are unanimous in finding the World Bank guilty, but it is not alone. It is backed up by other partners such as the World Trade Organisation, the International Monetary Fund and transnational corporations,' said a voice from India.

'People are having to die because they have no money. Even it is has no heart, the World Bank has an ear to listen. We need to eliminate the legitimacy of the new international order. We need to mobilise people to take to the streets,' said a voice from Sri Lanka.

On balance, the overall impression of the Assembly itself from participants was that it was a unique, transforming experience. It had a profound impact on the 1500 people who attended, and nearly all of them will have communicated with others about the experience in some way.

As a judge from India who attended said, 'The biggest achievement was making the world aware that the health of the common folk had to be a matter of international concern'.

What did not work?

The numbers of people, the diversity, and the various issues people wanted to discuss was both a success and a problem. Among the issues were:

- too many workshops: almost anyone who wanted to give a workshop could do so. Some attempt was made to combine similar themes into a single workshop, but there were still such a large number that many participants found it confusing.
- poor documentation: no overall report of the PHA, no list of participants, poor feedback from the workshops

- confusion over leadership and who was making decisions: for many participants, it was not clear who to ask for information, who was involved in the PHA organising group, and who could make a decision about changing something – for example, the agenda on the last day was changed overnight, much to the surprise of many of the participants
- No sense of what would happen in the future: what happens next? Who takes it forward? What happens to the 65 action points that came up on the final morning? No clear process was outlined to take forward these ideas. Even in the final wrap up meeting of the organising group after the PHA, there was no discussion about the obligations for the future. This took nearly a year to work out and has delayed the follow up.
- not enough time to organise with the people there.
- more analysis of what the people's stories mean in terms of strategies to combat globalisation.

What could be improved?

Media coverage was poor. Local and alternative media picked up the story, but it did not grab the attention of the international media. In today's electronic age, more could have been done to maximise the attention of the world's media. Journalists who were in Savar were generally unhappy about the lack of planning and notice for the few press conferences that were given. They found it difficult to predict when a story might be worth covering.

Programme: the structure of the testimonies in combination with workshops and the rest of activities planned for each day was a good idea. Nevertheless a critical decision might have been taken to restrict the number of workshop and presentations so that more work could have been done on moving forward strategically.

Daily evaluation from participants and daily summaries of activities would have helped to communicate key information and provide opportunities for feedback.

Lessons learned

Some of the major lessons that could be learned from the Assembly and that might be of use if similar events are held include:

- Ensuring that strategic action points are a desired outcome of any such Assembly and that background papers need to have an action orientation, something missing from the PHA background papers. Despite the many action points raised, without a process for analysing them and turning them into strategic activity, they remain good ideas on a flip chart
- Clarifying the leadership and governance of the activity – who is making decisions and how are decisions made; who is responsible for what
- Building in time and space for more informal sharing of experience – opportunities for people to display their work, to meet with others, to set their own agendas and explore issues that are important to them. Creating the opportunity for this to happen along key themes or among people from the same regions or cultures will facilitate future networking and horizontal communication. It will also mean that the 'formal' programme of the event

can be more focused, more purposeful, and more targeted towards developing clear strategic outcomes

- Maintaining and strengthening the presence of the community, the diversity of cultures, the presence of people's voices, and the 'spirit of friendship, solidarity and hope' that was present at the PHA.

'In the nature of the work that we are doing, we need to practice what we preach. The issue of 'democracy' is worth looking at: democracy is messy and time consuming. If you institute a consultation and then disregard it, there is no difference. The process matters. How we do it matters.'

- participant from the Philippines

Post-Assembly: building a movement

If the Assembly was inspiring, motivating, and energising for many of the participants – and the feedback from the evaluation process is that this was a very common experience – it was exhausting and sometimes demotivating for many of the people who were involved in its organisation.

One consequence of this was a real gap in follow up. This was compounded by a lack of resources – both financial and human. The Secretariat in Bangladesh was set up to facilitate and organise the Assembly, not to undertake the follow up. Although there had always been a sense that the Assembly itself was only one point in a process, the way in which that process could continue in a coordinated manner was not identified.

The immediate impact of the Assembly came largely through people who attended feeding back information on the event to others in their communities, colleagues in their organisations or networks, and by writing articles or reports for publications.

Slowly, national and some regional meetings began to be held in 2001 to share the experience of the Assembly, help disseminate the People's Charter for Health, and begin to explore what could now be done at a local level. These tended to be most evident in the places where strong pre-Assembly activity had taken place: south Asia, Latin America and a little in Europe.

The Charter was clearly the most important mobilising tool to emerge from the Assembly. Indeed, for more than a year, it was the only major document to come out from the Assembly. An official report was never produced (other than one that was communicated to donors).

Around the world, the Charter was translated spontaneously into local languages. Today, 27 language versions are on the PHM website (www.phmovement.org) and more than 40 language versions have been developed. The translation was done by local people and organisations because they recognised its value for their own work. That, in itself, is a powerful indicator of the impact of the participatory process that led to its development. It clearly resonated with the needs and hopes of many people and organisations around the world.

Three other mobilising tools that began to have some impact and have continued to contribute to the development of the movement were:

- Advocacy focused around the World Health Organization
- Networking
- The evaluation process.

Engaging with WHO

WHO was conspicuous by its absence at the PHA, despite having been invited at the highest level. WHO's Director-General was invited to make a major presentation, but declined to attend or to delegate anyone else to take part. This was noted and commented on during the Assembly, and it featured in some of the limited media coverage that was produced.

PHM representatives used opportunities in April and May 2001 to hold informal seminars within WHO headquarters about the People's Charter for Health and the PHM that attracted considerable attention. A small delegation was also able to meet with the Director-General. An outcome of the meeting was an announcement by WHO of the establishment of a Civil Society Initiative (CSI) to improve interaction with bodies such as the PHM, other movements and networks and the broad range of civil society actors involved in health.

In 2002, the CSI invited the PHM to present the People's Charter for Health at a technical meeting during the World Health Assembly, attended by the Director-General. During 2003, the PHM played a significant role in organising events to improve civil society inputs into the selection process for a new WHO Director-General, and conducted a series of seminars, particularly around the importance of primary health care, during the World Health Assembly.

Also during 2003, dialogue was opened up with the Pan American Health Organisation (PAHO) and with its new Director, Dr Mirta Roses. This led to PHM being invited to critique a planning document on primary health care for the Americas, to inform a ministerial meeting on the links between trade and health, and to co-host a conference on primary health care in Guatemala.

At the instigation of the WHO Director-General's office, discussion with the PHM was started by the units within WHO responsible for pro-poor policy and for increasing access to anti-retroviral therapy for those infected with HIV. This led to several WHO representatives coming to the PHM-coordinated International Health Forum as part of the World Social Forum held in Mumbai, India in January 2004. One of the WHO staff commented, 'PHM members throughout the world could add value to collaborative planning of country-based ART implementation programs.'

The stronger links with PAHO and the increased interaction with WHO – including WHO seeking out opportunities to engage with PHM – are strong indicators of the impact that the PHM is now having. So too is a Viewpoint article in a June 2004 issue of the medical journal, *The Lancet*, that highlights the role the PHM is playing in helping public health practitioners again focus on developing partnerships with communities.[1]

Networking

Networking and communication are part of an integrated process. Both featured strongly in the development of the PHA; both were initially lacking in the follow up to the Assembly.

A simple networking and communication tool – the contact details of the participants at the PHA – was a long time coming, and when it was produced, much of the contact information was not correct. One of the first uses of the contact information was the establishment of an international electronic discussion list: PHA-Exchange (see Box 4 for details).

---

[1] Beaglehole, R. et al. 2004. Public health in the new era: improving health through collective action. *The Lancet*. Vol 363, pp2084-6

One of the principal communication and networking tools used in the run up to the Assembly was the PHA website. Unfortunately, due to a combination of technical problems and some administrative oversights, access to the site was lost shortly after the PHA. As much of the information on the site was essential for the evaluation process (among other things), the Exchange programme – which had been asked to coordinate evaluation work – offered to recreate and regenerate the site. In late 2001, a new website was launched – www.phmovement.org – which was maintained by Exchange for 18 months until it was transferred to the PHM secretariat in early 2003.

A Spanish-language discussion list has also been started, initially with 54 participants. This is particularly being used to encourage horizontal communication among groups in different countries and to share experience.

Box 4: PHA-Exchange: a mailing list to link the globe

On 10 August 2001, Claudio Schuftan, one of the people involved in the planning for the PHA, started the PHA-Exchange mailing list. He was able to identify 449 e-mail addresses from among those present at the PHA in Dhaka (164 in Bangladesh, 35 in India, and 250 in the rest of the world). He described the list as 'the crucial networking system set up to stay in touch to consolidate our work worldwide. We will exchange experiences, share educational materials, do solidarity work, coordinate our positions for international meetings and for lobbying. In this day and age, the list is indispensable for our work as committed change agents.'

In the first month, 20 messages were sent, most of them being a way of disseminating electronic copies of some of the background documents from the PHA, and just 5 contributors* posted information to the list. By August 2002, there were 39 postings, made by 9 contributors, and more than 600 people subscribed to the list. The range of issues dealt with had broadened considerably: water, gender, armaments, nutrition, child health, human rights, health system resources, and a number of announcements of meetings, seminars and conferences as well as news of plans and developments in the PHM were among the issues covered.

By August 2003, there were 50 messages posted from 8 contributors, again covering a myriad of topics, and at least 700 people were signed up to the list, with about 5 new participants a week. In April 2004, there were 57 messages posted by 11 contributors. People from at least 40 countries are now regularly participating in the list. The issues included: nutrition, HIV/AIDS, human rights, gender, traffic accidents, the pharmaceutical industry, Iraq, rural health and a number of announcements about activities of organizations involved in the PHM.

*Note: as this is a moderated list, a large number of contributions are actually posted by the moderator, although originating from a greater number of people. The contributors indicator, therefore, is not very significant of usage of the list.

Electronic communication and networking are helpful, but in a people's movement, face to face contact is also important to strengthen relationships and build trust. By mid-2002, a series of dedicated networking activities were beginning to get underway to build and strengthen the connections that are necessary to sustain a movement. These included meetings and workshops in Africa, a travel tour in Europe, the events

around the World Health Assembly each year in May, a tour of the USA, and in 2004 a tour of Australia.

The impact of these activities is beginning to be seen in 2004 in terms of the new vibrancy of contact, frequency of interaction among key stakeholders in the movement, and the quality of the dialogue. Internationally, PHM is beginning to have a presence; locally in an increasing number of countries, there is a development of stronger local groups that reflect people's concerns.

The evaluation process

When Exchange began the evaluation process in 2001, some issues were very obvious immediately:

- Limited resources were available for follow up
- Communication was poor
- There was limited organisational capacity or involvement in some countries or regions (Africa was a particularly under-represented region).

It was not necessary to wait for an evaluation report to begin to address some of these issues. As a result, Exchange designed the evaluation process to be participatory and to strengthen the possibilities for communication and interaction among many of the organisations that were part of the movement.

The style of reflection workshops that Exchange used in Latin America, Africa and internationally, provided opportunities not simply to reflect on the PHA, but also to bring together many of the key players in the PHM to begin to plan collectively and look for opportunities to undertake joint activities, as well as to learn from each other and strengthen the links among them. Reports of the Latin American and African meeting are included in Appendix 4 and 5. Box 5 (below) captures some of the sentiments of the participants at the Latin America workshop about what is significant and different about the PHM.

Box 5: 'A revolution of hope' - the view of the PHM from Latin America

During the reflection workshop held in Nicaragua in late 2001, participants identified the specific characteristics that they felt made the People's Health Movement different and complementary to other social movements or networks.

It is a call to **all** peoples for the creation and development of a **transforming power for society**. The movement is not exclusive; it calls on all peoples to constitute a force to create substantial and significant changes in their different societies.
It is a **unifying** movement.
It proposes **a different revolution**: a revolution of hope.
It is a **solidarity** movement.
It struggles for the **dignity of people**.
It is a movement **rooted in the community**.
It shakes **awareness**.
It generates a **sense of belonging**. It offers participants the possibility of becoming part of a great movement of social transformation. Participants do not feel isolated, but connected and coordinated with common purposes.

Few of the people who attended the workshop in Africa had been at the PHA. So it was an opportunity to share through oral testimony and a video some of the spirit of Savar and bring new people into the movement. One of the decisions made at that meeting was to take an opportunity of a larger global forum organized by the World Alliance for Breastfeeding Action (WABA) later in 2002 to present the Charter, do networking, and have a further opportunity to plan collectively.

The purpose of this type of evaluation approach was not simply to collect information, but to create communal spaces where participants in the movement could reflect on their action and improve their future activities. It was hoped that this would also stimulate a continuation of this type of reflection. In early 2004, this occurred during a meeting of the PHM Steering Group.

The issue of communication – both internally and externally – was a recurring concern during the evaluation process. In May 2003, the evaluation team prepared a background paper – Communication Matters! (see Appendix 9) – to assist the PHM Secretariat in developing a more consistent approach to communication. This has been worked on, and changes implemented to improve the way in which communication is dealt with by the Secretariat, and increasingly, by many of the participants in the movement. It is encouraging to see, for example, in early 2004, the increased flow of reports and news about the work of people in different regions of the world.

Governance, leadership and decision making

As mentioned earlier, critical issues at the PHA included concerns about how decisions were made, who were the 'leaders' of the assembly process and who could influence and help to direct the process. Those concerns are also important in the post Assembly period around how the new movement takes shape and moves forward.

It was not until October 2001 that the first significant post-Assembly planning meeting was held in Savar, Bangladesh, with a small group composed of some of the members of the original organising group and a few others. This meeting helped to elaborate a possible governance structure for the PHM – one based on interacting circles (see Appendix 10 for details).

Three types of circles were proposed:

- Regional
- Issue-based
- Secretariat support.

The regional circles were seen as playing a dual role – to act as part of the governance process of the overall movement and to help to strengthen work and reach out to others in particular regions. The issue-based circles were seen as ways to link with and involve in the movement a number of networks and organisations that were focused on particular topics. These circles were seen as ways to identify, stimulate and sustain campaign focuses and areas where action might be taken. The Secretariat support circles were seen to be ways of providing advice and in some cases take on actual work that would need to be carried out.

In 2004 the PHM Steering Group reviewed the work of the circles to see which were working best and why. Several conclusions emerged, including that

- circles that respond to specific events or focused campaign issues tend to work in a more sustainable way
- circles that evolve mainly as a study circle do not tend to progress well unless they have a specific focused output
- involvement in issue based circles is limited unless the issue relates directly to the ongoing work being undertaken by members.

The relevance of this review and reflection on the circles is that it is part of the process of helping to clarify ways of working within the PHM, ways in which flexible and adaptable approaches can be linked together in new and different ways according to what works best in a particular region or in response to a particular situation. This is an indication of new ways of working evolving that are more inclusive, that challenge traditional hierarchical organisational processes, and that ultimately can improve linkages and interactions.

Critical to this process is a clear set of overarching strategies or frameworks into which the work of the circles can fit and which ensures that any coordinating structure is also an enabling structure.

Frameworks for action

What does the PHM do? Who decides what it does? How do those decisions get made and how are they communicated? These are some of questions that have been continually confronting the leadership of the PHM since the PHA.

There is a strong tension between supporting the creation of the democratic spaces where ideas and actions can emerge from the struggles that people are facing on a daily basis in their efforts to improve their health, their family's health and the health of their communities and the need to have some coordinated approaches where unified global action can be stimulated to advocate for change.

Both are needed. One without the other is a recipe for failure and ineffectiveness. A global campaign without participation is meaningless; a powerful local action demand that does not reach policy makers and influence their decisions simple fosters a sense of defeat and despair.

One of the roles of the PHM has to be to identify from the diverse voices among its participants, where are the common issues – privatisation of health services, the impact of conflict, the introduction of trade agreements that are not pro-poor, are simply three of the more obvious global concerns – where mobilisation and action can be more coordinated. This does not mean that PHM has to set the local agendas; rather it works with a range of local agendas and helps to craft a unifying approach and banner under which all can march.

In 2003, the PHM began to do this, with its year of action around the 25th anniversary of the AlmaAta Declaration on primary health care. Around the world, groups organised their local activities to mark this. The PHM supported these efforts through collating a set of documents that provided a comprehensive background to what the

Declaration meant and what progress had been made in trying to achieve its aims. At the same time, PHM launched its 'Million Signature Campaign' together with the International People's Health Council (IPHC) to call for government and international action now to respond to people's right to health.

In one of the evaluation sessions, someone described the PHM as a 'young movement with wisdom'. There are people, organisations and networks involved in the movement with vast experience of local and international advocacy, community mobilisation, and solidarity work. For many, the PHM is a new opportunity to work together with others. The experience is valuable; so too is the new learning that is beginning to emerge about how to structure relationships in ways that will be productive and effective. It took about two years after the PHA to see this wisdom begin to have an impact within the movement. Now, in mid-2004, it is safe to begin to describe PHM as a young, strong, and growing movement, one that is drawing on a wealth of wisdom, knowledge and experience from around the world, and one that offers hope that social change to improve people's health can become more of a reality.

Lessons learned

During the period from the end of the PHA to the present time, many lessons have been learned and increasingly are being put into practice to improve the work of the PHM. These include:

- the need for more coordinated communication and information sharing – internally, there is now increased dialogue and communication among key movement focal points. Externally, there is a greater visibility of the PHM in some arenas and fora. More could be done, but the signs are encouraging.
- the importance of review and reflection processes to stimulate analysis of the work, rather than simply undertake activities – this is increasingly being incorporated into PHM steering group sessions and is enabling a more strategic vision to emerge
- allowing more time for planning and coordination of strategy – in 2003, there was a strong urge to have a second PHA sometime in 2004. It soon became evident that there was insufficient planning time for such an event and it has been put back to 2005. This has also allowed for a recognition that although there was no model for the 2000 PHA – as one participant commented 'This was the first time that people had organised their own event. What model did we have? We were working with a model of conferences and workshops that we are all used to, often set from a top-down perspective, expert driven.' Now there is a model, imperfect and in need of improvement, but the planning time is now available to make those improvements.
- better documentation of activities – which relates to internal and external communication. Internally, there is now much better documentation. This still needs to be better translated for external audiences to make more use of the communication channels that PHM has available, but it is an essential first step.
- more clarity and transparency on how activities are funding, how funds are being shared and made to work more effectively in combination and with complementarity. The concept of PHM participants bringing their own contributions to the table to enable things to happen, rather than looking to

PHM (particularly the Secretariat) as a source of resources is beginning to be internalised. This focus on contributions is one of the key indicators in determining the strength of a network or a movement.

- the importance of prioritising and selecting key areas for action – the Charter has a wealth of action points. Any meeting or workshop is capable of generating long shopping lists of things that need to be done. Selecting a few of these that can be done is a skill that enables action to be effective. This is something that the PHM needs to continue to develop and practice to enable it to maximise its impact.

Conclusions

There were seven outputs identified in the original project proposal for the PHA. In Table 3, these outputs have been assessed in terms of pre-Assembly, the PHM itself, and the PHA follow up. This assessment is based on the dialogues that the evaluation team has had over the past three years. It is, however, the assessment of the evaluation team that we have tried to synthesise from a range of perspectives. Other people, undoubtedly, have different views on this. Certainly, if we had prepared this table 18 months earlier, it would have portrayed a more negative picture in terms of the post-PHA follow up.

Table 3: Meeting the project goals

PROJECT GOALS	Pre Assembly	PHA	Post-PHA
1)Hearing the voices of the unheard	3	4	3
2) Reinforcing health as a cross cutting issue	4	4	3
3) Formulation/Adoption of Charter	5	5	5 - Promotion of Charter
4) Sharing and enhancement of knowledge, skills, motivation, and advocacy for change	3	4	3-4
5) Improvment of communication between concerned parties /groups/institutions	3	2	3
6) Development and enhanced cooperation between concerned actors in health field	3	2	3
7) Enhance media interest in health equity issues	0	0	2

Ranking out of 5 where 0= not at all; 5 = completely meeting the goal or objective

This underlines the point that the development of the PHM is a social process, one that it is difficult to accelerate. It takes time to build trust, relationships, working practices and principles. There are times when that process will look smoother than others. Therefore it is important that there is a continual reflection process within the PHM to focus not simply on the results, but on the way those results were achieved. The types of questions the evaluation team has been using (see Box 6 below) may be helpful to guide reflection.

Box 6: Indicators of change

- Has there been enhanced cooperation among key individuals and organisations active in public health?
- Have people most at risk from poor health conditions played an active and central role in the planning, development, leadership and governance of the PHM?
- Has the PHM enabled dialogue and discussion at various levels and in different arenas to encourage change in policies and practices affecting people's health?
- Has the PHM evolved effective internal and external communication strategies to ensure active participation, inclusion and impact?
- Is the PHM an appropriate platform for facilitating the voices of the unheard to be heard?

In early 2004, the answer to those questions could mainly be ranked at a 2 or 3 level (out of 5), but with indications of an upward trend. Things are tending to move in the right direction:

- There has been some enhanced cooperation. Links that are evolving with the World Social Forum, the strengthened connections with WHO and PAHO, the development of working relationships with the Global Equity Gauge and Medact around a global health watch process are simply a few of the most visible positive trends.
- Enabling dialogue and discussion in a number of forums is increasing, but there is scope for more. The Secretariat is demonstrating leadership in this, as are some national groups. The AlmaAta-related meetings throughout 2003 are good examples.
- Communication strategies and practices – both internal and external – are improving. Again the Secretariat is demonstrating leadership, but the response of many participants in the movement to share information is becoming more evident.

An area that is more difficult to assess is the degree to which the voices of the unheard are more evident, including in the planning, leadership and governance of the movement.

People's voices

A key issue that emerges from the evaluation is the degree to which people's voices are heard. When the PHM published a booklet of some of the testimonies from the PHA – *Voices of the Unheard* – it noted that the stories 'enable links to be made between the everyday realities of people, policy making and global politics which can in turn strengthen policy development at the local, national, regional and international levels'. For that to happen, for the realities to have impact, considerable work needs to go into strategic positioning of the stories and the messages they contain. Support for the people whose voices are being raised needs to be strong. Their capacity to express themselves in ways that will impact policy audiences needs to be developed. And they need to be engaged in the analytical process that helps to draw out meaning from their experience, that helps them, in the words of Saul Allinsky, to digest that experience.

Their satisfaction with the results of any policy dialogues needs to be continually assessed. This is one of the biggest challenges facing the PHM – maintaining and sustaining its links with people where they live and enabling them to play a major role in determining and driving the multiple agendas of the movement..

Linkages and alliances

Related to this is the issue of linkages to other networks, movements and organisations that are working on issues that impact on health. Enhanced cooperation is important so that the PHM is visibly seen as a pro-active, inclusive and welcoming movement and is a platform that enables people to participate, without them having to convert to a particular belief, ideology or approach.

The synergy and interaction between the PHM and the International People's Health Council (IPHC) – one of the original eight groups involved in developing the PHA – is an example of this. IPHC's strengths are particularly in its analytical work which is enhanced because of its history of being rooted in popular struggles to improve health in many countries. Box 7 expands on this relationship.

Box 7: Two complementary processes

The emergence of the People's Health Movement should be considered as a significant achievement to which the IPHC has had a crucial contribution. The PHM has provided the IPHC a near perfect vehicle to ventilate its ideas and calls for political action among a broad international public. At the same time, however, the PHM constitutes a threat to the IPHC since it may dilute – and has already done so, to some extent – IPHC's profile as an analytical group and its lobby towards more political pressure for real social change.

The possible amalgamation of IPHC into PHM was unanimously rejected. All interviewees saw a need for IPHC to maintain itself as a network because of its clear political purpose. The PHM is much more a broad movement, which does not articulate its political position the way IPHC does.

- from The International People's Health Council and the Globalisation and Health Project – evaluation, 2004.

Media and the enabling environment for social change

An area where the PHM has underperformed – although there are signs of improvement – is in generating media interest and helping to shape the external environment so that dialogue on public health issues is more of a reality. This is not an easy area of work and forging stronger and more effective alliances with networks of media personnel and those that work with media is likely to be a useful strategy to pursue.

Diversity

One of the exercises that the evaluation team did with nearly 80 people in 2003 in Geneva was to encourage them to identify how they came into contact with the PHM and how they pictured their involvement. The routes, the pathways, the doors through which they entered were diverse and spread over time. Some described hearing of the very first germs of the idea, back in the mid 1980s. Others spoke of the moment when a colleague who had been at the PHA in Savar shared their experience and how motivating that was. Some talked of the way the work they did in another sector had a clear link with the PHM.

The images of the movement that they drew were also diverse, but had some common elements. The ideas of joining hands, connecting and working together and of waves of energy, surging and growing were two powerful currents. Above all, the pictures they drew were a celebration of diversity and it is that diversity that is the main strength of the PHM. Sustaining and maintaining a diverse, flexible and effective movement that serves as a platform for social change is the challenge that now faces the PHM.

Appendix 1: People's Health Assembly (PHA) Evaluation Concept paper

Introduction

As a starting point, it would be useful to define what is meant by **evaluation**. In this document, and in the process that it describes, evaluation is taken to mean *an analytical process that seeks to learn from and understand the experience that it is investigating*.

Within that process, there are two complementary approaches to take. One approach will be to look at the events and activities leading up to the People's Health Assembly (PHA) and the Assembly itself and the other approach will be to look at efforts underway to develop follow up activities. Obviously, it is somewhat easier to review and reflect upon what has already taken place than it is to assess ongoing activity. At any point, the ongoing activity is in transition to somewhere else. Any assessment, therefore, can only be an indication of the trends towards ultimate objectives.

In both cases, however, there is scope to help document the activities that are being undertaken, to reflect upon them in a participatory manner, to identify lessons, to feed those lessons into ongoing activity and to identify ways of sharing those lessons more widely among organisations doing similar work. (Although the PHA was in many ways a unique event, it is a form of social mobilisation that occurs at other scales within the health sector and in other sectors. Valuable lessons can therefore be useful to improve effectiveness of social mobilisation and advocacy activities elsewhere.)

Within the timeframe envisaged – between mid-May 2001 and end March 2002 – by necessity, most of the focus of the evaluation will be on the pre-Assembly activities and the Assembly itself. However, it should be possible to work with organisations involved in the PHA follow-up to establish a set of methods for documenting and analysing continued learning, and to facilitate understanding of the learning.

Evaluation team

To try to reflect some of the range of culture and language involved in the PHA process, it will be useful to have a multicultural team. We are proposing having a four-person team led by Andrew Chetley of Exchange (supported by other Exchange staff) and provisionally involving someone from Peru, Tanzania and the Philippines. The team will be balanced in terms of gender and in terms of people who have been involved in some way in the PHA process and those who have not. At least one, and preferably two face-to-face meetings of the team will be required.

What will the evaluation cover?

The logical framework for the main project proposal sets out a series of outputs and measurable indicators that can be used to assess progress. There are also less quantifiable issues that emerge from a communication perspective that can be used by the evaluation team and by participants to help reflect on each of these outputs and assist in the learning process

The 7 identified outputs are:

- hearing the unheard
- re-enforcement of the principle of health as a broad cross-cutting issue
- formulation and endorsement of a People's Health Charter
- sharing and enhancement of knowledge, skills, motivation and advocacy for change
- improvement of the communication between concerned groups and institutions
- development of enhanced cooperation between concerned actors in the field

- enhanced media interest in health/equity issues.

The broader indicators could include:

- What (if any) increase has there been in public and private dialogue and debate around the key issues highlighted as part of the PHA process?
- Is there increased accuracy of the information people share in the dialogue and debate?
- To what extent were the people centrally affected able to voice their perspective in the dialogue and debate? (Which groups are most disadvantaged? How were they supported to voice their views? What happened?) Pay attention to gender issues here; also children, disabled, and the perspective of users of health care systems
- Has there been an increased leadership role by people who are disadvantaged? Who made the major decisions about the planning and operation of the PHA? How were people centrally affected engaged in the decision making process? Any example where the involvement has led to changes in strategy or fine tuning?
- To what degree does the debate and discussion resonate with people's everyday issues? what issues provide the focus? How were people energised/mobilised by these issues? What actions followed?
- Has it linked people or organisations that might not otherwise have been linked? Which groups? What are their interests? How linked? Has an alliance been formed? How does it work?

A key feature of the evaluation will be its efforts to collect already documented information about the mobilisation processes used and the lessons that can be drawn from them. As well, the evaluation team will help to record and document new and additional analysis of the processes and will encourage organisations engaged in follow up activities to undertake regular review, reflection and documentation as part of a continuing and sustainable learning process. In doing so, the evaluation team will work with the PHA Organising Group to develop and strengthen the evaluation component of any follow up work.

Methodology

The evaluation will use a combination of techniques and a variety of sources and informants to reflect the diverse nature of the PHA participants and their interests. The evaluation team will review all available documentation about the PHA process globally. It will also review available information on a selection of regional or national preparations, in order to develop at least four case studies that illustrate different preparation models. Structured, semi-structured and open-ended interview techniques will be used to elicit feedback from participants, organising group members, media, and other interested stakeholders (such as the donor community).

A simple and easy to complete questionnaire will be sent to all identifiable participants. Focus group sessions will be held with participants from at least four regions. Where possible, these discussions will be planned to coincide with or be part of PHA follow up activities. Use will also be made of any electronic discussion lists that have been established (such as the European PHA list, the Latin American list, and the Organising Group list) to encourage a brief discussion that focuses on evaluation questions.

The evaluation will target:

participants at the PHA: through a structured and easy to complete questionnaire and through follow up interviews with a selected group of them. Where there are large numbers from a particular country or opportunities to meet with a number of people from a particular region, focus group discussions will be organised to enable those whose voices are not usually heard to play a key role in the evaluation

members of the coordinating group: particularly through key informant interviews that will use a semi-structured interview guideline, so that consistent questions are being asked

media, particularly, but not only, those who attended: this is likely to be through key informant interviews, and will include exploring with media representatives who did not attend what they know about the PHA

policy makers, including donors and international agencies: through some exploratory questions to a representative sample of national policy makers, representatives from key donors and from staff of international agencies, and with follow up interviews where possible.

(For example, the issues raised in the Charter around the transformation of the UN system, and the global financial and trading system to be more responsive to the needs of the poor offers an entry point to explore with such policy makers the degree to which they feel the need to respond to the PHA process.)

Ideally, a draft of the evaluation report will be prepared for a meeting of the PHA Organising Group at which it can be discussed by the Group with the evaluation team. This could lead to a revised report and plans for integrating evaluation into the follow up activities.

Timeline

Attached is a timeline that indicates the planning stages for the evaluation. Preparatory work will be done during May and June, data collection from July to October, analysis and drafting during November and December with a presentation of a draft report either in December or early January. The evaluation report will be finalised by end-January 2002. An option to consider is to also aim to hold a dissemination workshop to discuss the evaluation findings and establish ways of integrating learning processes into follow up work. This could be planned for March 2002.

Evaluating the evaluation

Because of the unique nature of the PHA process and the complexity of the evaluation exercise, Exchange will undertake to monitor and evaluate the evaluation process itself to identify what worked and what was less successful. Partly, this will be integrated into the overall evaluation of the Exchange programme. A provisional figure of £2,500 will be allocated from Exchange's funds to cover costs of using an external researcher to assist in this. These findings will be shared widely. This part of the exercise is likely to be carried out after March 2002.

Budget

The total budget for the basic evaluation work comes to £31,000. This covers the costs of researchers, including Exchange staff, the travel costs for the evaluation team, local costs incurred by researchers, a contribution towards up to three local or regional meetings at which focus group or other evaluation discussions can take place, and administrative support. Of this total, the Exchange programme will be able to meet £20,000. This leaves an outstanding balance of £11,000 to be met from other sources. An optional dissemination meeting and the evaluation of the evaluation would add a further £17,500, of which £10,000 would be covered by Exchange.

All costs are in UK£		**Costs**	**Exchange funds**	**Other funds**
Exchange staff	40 daysx£150	6000	6000	
Other researchers	20 daysx£150x3	9000		9000
Evaluation team travel		6500	6500	
Local costs		1500		1500
Local/regional focus meetings	3	7500	7500	
Admin support		500		500
Sub-total		**31,000**	**20,000**	**11,000**
[optional dissemination meeting]		15,000	7,500	7,500
Evaluate the evaluation		2,500	2,500	
Total		**48,500**	**30,000**	**18,500**

Appendix 2 : LOG FRAME Project Proposal

Health Rights for All – People's Health Assembly Process			
Project Summary	**Measurable indicators**	**Means of verification**	**Important assumptions**
Goal			
To re-establish health, with an emphasis on Primary Health Care, and equitable development as top priorities in local, national and international policy-making.	η. Health and equity given clearer priority in policies of national governments, UN institutions (including WB, WTO, WHO, the EU) and corporations. ι. Shift in health resource allocation (human and financial) towards the needs of the poor and marginalised. φ. Degree of inclusion and prioritisation of health/equity concerns in policy making, both in the health sector and in other sectors. κ. Statements promoting health and equity expressed in policy fora of national governments, the G7, and international organisations such as the World Bank, WHO and WTO, λ. Progress on translation of 20/20 initiative put into practice in respect to the health sector	a. Statistics of WHO, UNDP (Human Development Report) over a 5-10 year period. b. Local monitoring by PHA process participants c. Report of monitoring of local and national policy-making as well as policies and actions undertaken by international organisations, d. Report of the monitoring of statements promoting equity in health. e. Report of monitoring the allocation of resources (human and financial, qualitative and quantitative) to health, over a 5-10 year period. f. OECD reports	Strengthened political will to genuinely work towards the International Development Targets.
Purpose			
To develop and begin to implement strategies for achieving the goal of Health for All based on the knowledge and experiences of different groups and communities around the world	Integration of lessons and proposals from the PHA process in policy statements by national governments and municipality authorities, EU (including EU Development Council of Ministers, European Parliament, EC) the UN system (including WHO, WB, WTO, etc.), Regional Development Banks and corporations.	• Reports from monitoring Policy statements.	a. Access of people's movements and citizens organisations to the PHA process. b. Commitment and capacity of PHA process participants and the networks, communities and organisations that they represent, to ensure the time and resources necessary for advocacy activities.

Outputs			
Project Summary	**Measurable indicators**	**Means of verification**	**Important assumptions**
1. Hearing the unheard. Presentation of people's concerns and initiatives for better health, including traditional and indigenous approaches. Women's rights, concerns and full participation will be given high priority. Action plans will be worked out, refined, and presented to decision-makers locally, nationally, regionally and internationally.	- A minimum of 100 people's stories and case studies to be collected from all regions of the world. - Publication of a majority of the collected stories and case studies on the web. - Publication of selected, representative stories, case studies and analytical papers in at least one major publication after the PHA event. - Dissemination of at least 10 selected stories/case studies as background discussion material for local/national and regional pre-assembly meetings. - National and regional events in 2001 to enable sharing of PHA process experiences and recommendations including the PCH. - Publication of at least 100 media features (articles, radio and TV) based on people's stories, case studies and analytical material generated through the PHA process. - Particular emphasis on women's, indigenous people's and other marginalised groups concerns in the formulation and endorsement of a *People's Charter for Health*. - Development of 11 Regional Action Plans, with targets for 2001. 1. Direct participation of representatives of minorities and marginalised groups in the PHA process. 2. A senior WHO official to attend the whole PHA event. - At least 20 officials of governments and international organisations to attend the PHA event. - PHA key documents produced in a minimum of five major languages and two regional languages to enable broad participation in the process.	- Regular reports generated by the monitoring and final evaluation of the project. • Action plans - Reports on the monitoring implementation of Action Plans. - Documentation of contacts of participants and network with appropriate health related decision-makers locally, nationally and internationally. - Lists of participation. - Translated documents • Articles and video/audio tapes	

Project Summary	Measurable indicators	Means of verification	Important assumptions
2. Re-enforcement of the principle of health as a broad crosscutting issue. There will be emphasis on the inter-sectoral dimensions of primary health care and focus on health development, rather than health services.	- Increased inter-sectoral co-operation including degree of participation of Health Ministers in fora discussing cross-cutting issues e.g. poverty eradication and environmental policies. - Participation of other ministers in fora engaged with health. - Initiating of discussions about inter-ministerial task forces. - Discussion of concept of Health Impact Assessments in other sectors. - A majority of analytical papers collected and generated in the PHA process that do not focus on the health service sector - Representation at the PHA of 100 participants that are not primarily health service oriented.	- Specific studies and monitoring - Through regular evaluation of the project.	
3. Formulation and endorsement of a People's Charter for Health (PCH). To include concrete recommendations for policy and action with clear commitments to promoting equitable, gender-sensitive and sustainable health development. To be addressed to governments, international organisations, the business sector, academia, non-governmental organisations and people's movements.	b. Existence of draft PCH at the time of the PHA event, formulated through broad participation of individuals and organisations during the pre-assembly process. • Endorsement of PCH at the PHA event. - Subsequent presentation of PCH at national and international levels in all relevant areas and fora (e.g. individual governments, EU, UN organisations including WHO, WTO, WB and to international and national CSO's - Translation, publication and distribution of PCH into a minimum of 5 'major' languages and many regional languages. • Adoption of PCH by at least 1,000 networks and numerous CSO's.	g. The People's Charter for Health h. Translations of the PCH i. List of endorsements of the charter (during and after the PHA event) j. Reports of number and character of meetings where the PCH has been presented.	

Project Summary	Measurable indicators	Means of verification	Important assumptions
4. Sharing and enhancement of knowledge, skills, motivation and advocacy for change Throughout the PHA process, opportunities will be provided for in-depth exchange of experiences and development of both practical and analytical skills. The People's Charter for Health will provide a base for advocacy, policy-formulation and campaigns at the local, national and international levels.	• Formation and consolidation of international south-north advocacy networks and projects to follow up and advocate on specific areas and themes of the PCH. • Translation, publication and distribution of a minimum of 6 background discussion papers, 50 issue papers and the People's Charter for Health. ▯ Facilitation of at least 11 regional meetings ▯ Number of skills- and capacity-building workshops during local/national/regional meetings. ▯ Compilation, publication and distribution of a minimum of 100 'People's stories and case studies' expressing people's positive and negative experiences in health. ▯ A minimum of 25 national level fora on post-assembly lobbying and strategies. ▯ Distribution of at least 10 selected representative stories/case studies as background discussion material. ▯ PHA process key documents produced in a minimum of 5 languages to enable broad participation in the process. ▯ Participation of at least 100 people in the 'Follow-up Forum' immediately following the PHA Event. Teach-ins, workshops and training sessions to be offered by participants. ▯ Participation of at least 50 people in field-trips/exposure trips in connection to the PHA Event and Follow-up Forum.	• Establishment of network • Reports of regional meetings, workshops and events	

Project Summary	Measurable indicators	Means of verification	Important assumptions
5. **Improvement of the communication between concerned groups and institutions.** Communication and networking among individuals, groups, organisations (including people's movements) and institutions will be developed during the Assembly and sustained and strengthened thereafter.	- Organising of 25 national, 11 regional and numerous local meetings (before and after the PHA event) - Information on the progress of the PHA process distributed to concerned groups, institutions and individuals regularly (electronic and ordinary mail). - Development and use of a PHA web-site - Development of resource base and compilation of address lists of participating and other relevant organisations. - Strengthening of capacity of participants and their networks/organisations to use web and email based communications • Establishment of PHA process advisory group for co-ordination of follow-up activities and advocacy - 10 regional same-language based exchanges/meetings in 2001.	• PHA process monitoring • Report of training programmes • Number of e-mail groups established	
6. **Development and enhanced co-operation between concerned actors in the health field.** The importance of strengthening the links between the different institutions and actors in the health field will be emphasised.	- A High-ranking official of the WHO to attend the PHA Expanded dialogue with WHO at central, regional and local levels. ▪ Agreement by WHO of new, progressive policy on interaction with CSO's. - Participation of PHA-related CSO's in at least one regional health forum sponsored by WHO. - Establishment of official NGO status with the UN for at least 20 PHA-related CSO's during a three-year period. At least half of these not primarily health-sector oriented. 7. Establishment of mechanisms for co-ordination and support of networks stemming from the PHA process - Events in the EU in 2001 to enable sharing of PHA process experiences and recommendations including the PCH with health professionals, journalists, trade unions, and other interested CSO's - No. of meetings of PHA process advisory group for co-ordination of follow-up activities and advocacy	- Attendance at PHA - Specific studies and monitoring	

Feedback on the People's Health Assembly process

The People's Health Assembly process set out to achieve a number of objectives. The first few questions on this form are designed to get feedback from you about how much you think has been achieved so far. They should take only a few moments to complete.

The second section asks you to think about and reflect on your experience of the PHA process – before the Assembly in Savar, the Assembly itself, and anything that has happened afterwards. This also includes an opportunity to express ideas about what could have been done differently or better. This may take a little longer – five to ten minutes.

The final section asks for your suggestions about what should happen next, what the growing PHA Movement could be doing, what you think would be helpful to enable you to take the process further. Again, this might take five minutes or so. There are also a few optional questions at the end that could help us to better analyse the information.

Please take the time to complete this form and send it back. The feedback we receive will help the PHA Secretariat to plan for any future activities more effectively and will help to identify lessons that can be of use to others.

Part one:
(please mark an x in the box next to the answer that you think most answers the question)
To what extent do you think that the PHA process to date has:

1. helped to hear the voices of the unheard?
[] Very much [] Some [] Don't know [] Not really [] Not at all

2. communicated the idea of health as a broad cross-cutting issue?
[] Very much [] Some [] Don't know [] Not really [] Not at all

3. shared and improved knowledge, skills, motivation and advocacy for change?
[] Very much [] Some [] Don't know [] Not really [] Not at all

4. improved communication among concerned groups and institutions?
[] Very much [] Some [] Don't know [] Not really [] Not at all

5. improved cooperation between concerned actors in the field?
[] Very much [] Some [] Don't know [] Not really [] Not at all

6. increased media interest in health/equity issues?
[] Very much [] Some [] Don't know [] Not really [] Not at all

7. increased the involvement of poor people in taking decisions that affect their health and well being?
[] Very much [] Some [] Don't know [] Not really [] Not at all

Part two:

8. How did you first hear about the PHA process?
[] mailing [] e-mail [] website [] article in a newsletter
[] word of mouth [] brochure
[] other (*please specify*):

9. Why did you get involved in the process or attend the Assembly? (*If you give more than one reason, please give what you think is the most important reason first.*)

10. What do you think is the biggest achievement of the PHA process?

11. What for you is the most memorable or significant moment of the Assembly itself?

12. Was there anything else that you particularly liked about the Assembly?

13. What do you think was the least successful part of the Assembly?

14. Were there any other aspects of the Assembly itself that you think could have been improved or done differently?

15. As part of the process, have you met with and been able to link with people or organisations doing similar work that was not possible previously? (*If yes, please give an example.*)

16. After the Assembly, did you do any of the following?: (*please put an X in as many boxes as are relevant*)
[] discussed the Assembly with colleagues
[] held a meeting/workshop to share the outcomes
[] translated the Charter (*please send a copy*)
[] distributed the Charter to others
[] wrote a report about your experience (*please send a copy*)
[] wrote an article for a newsletter or journal (*please send a copy*)
[] provided information to the media about the PHA/Charter
[] got involved in an ongoing campaign
[] contributed to an e-mail discussion
[] put information about the PHA or the Charter on your website (*please provide your website address):*
[]started a new campaign
[]wrote/e-mailed or phoned someone you met at the Assembly
[] other (*please specify*):

17. Are you aware of any activities being carried out by others after the Assembly?

Part three:

18. What do you think is the most important thing for the PHA Movement to do now?

19. What could the PHA Movement do that would most help you in your work?

20. Is there anything that you are doing (or could do) that you think could contribute to strengthening the PHA Movement?

Please add any additional comments:

Optional questions:

O1. Is the organisation you work in/with a: (*please mark an X in as many categories as are relevant*)

[] government ministry/department [] non-governmental organisation
[] academic institution [] donor agency/foundation
[] health care facility [] network
[] consumer organisation [] community based organisation
[] media/communications organisation [] consultancy/self-employed
[] other (*please specify*):

O2. What country are you based in?

O3. Are you?: [] male [] female (*please mark an X in one box*)

Q4. Would you like further information about?: (*please mark an X in as many categories as are relevant*)

[] results of this feedback study [] other PHA activities
[] the work of Exchange

Please provide your e-mail address, fax number or current postal address if you have selected any of the above choices.

E-mail:
Fax:
Address:

Please return this form by e-mail to:
Andrew Chetley, Exchange: chetley.a@healthlink.org.uk
Or by post or fax to:
Andrew Chetley, Exchange, c/o Healthlink Worldwide, 40 Adler Street, London E1 1EE, UK.
Fax: +44 20 7539 1580

Appendix 4: Latin American Focus Group Report Managua, Nicaragua , December, 2002.

An evaluation meeting held in Managua, Nicaragua in December 2001 provided a space to reflect on the process of the PHA – before, during and after the meeting held in Bangladesh in December 2000. Thirteen people attended the workshop which was facilitated by Roberto Lopez. The participants included some who had been involved in preparation work for the PHA, some who had attended the PHA and some who were not able to attend, but who had been involved in follow up activities.

Before the PHA: what motivated people to take part in the PHA process?

In many parts of Latin America, including among indigenous populations, both urban and rural communities and among civil society organisations, the struggle for health has been part of the dialy agenda. For that reason, the proposal to organise a global assemly where representatives of the world's poor would be present appealed greatly and was eagerly taken up by those who received an invitation to become involved in the process.

In all the countries, people working at the level of the people and for their interests had developed forces to communicate to the people in the spirit of Alma Ata, searching for health for all. There were strong national and subregional movemtns for health – for example in Brazil and in Central America) with the relevant participation of civil society organisations, including the church. Health is stated as the main concern of many organisations and the health conditions of the population are a very concrete expression of the consequences of the economic models that are applied in the countries.

In this form, the development of the PHM builds on a long and popular tradition of rich experience at community level and in other settings. The PHM appears as a clear ideological proposal of public health that responds also to the frustrations about the proposals and experiences before Alma Ata, the frustration about the castration of the primary health care strategy in favour of the call for selected primary care. The PHM revitalises as well the impulse of the NGOs who work in the health field which developed in previous decades and give an impulse to the NGOs who work in the health field for the interests of the poor. The PHM presents now as a necessity and as a solidarity response for the poor to change the direction of national and international policies that affect the wellbeing of the people. The PHM is in tune with the antiglobalisation movement and responds to the need of the people to join and stengthen forces.

The PHM raises the spirit after the frustration produced by the lost decades in which there has been practically an ideological castration of the civil society organisations and the cooption of much good will, movements and organisations caught up in a perspective of support to neoliberal and anti-people proposals. The PHM looks at health as a strategic theme which affects the whole society and that can help to combine people and organisations in a new hope to existing organisations and help to develop a new militant policy

to encourage a generational recomposition. It suggests that the power of the people is an important tool to succeed in health for all.

Process of the Assembly and empowerment of the poor

In all the countries where there was a preparation process for the Assembly, there were diverse activities through which the people were organised and able to participate actively in the discussions and formulation of proposals. For example in the case of the municipal councils of health, and the dialogue at the grassroots (Mexico), the discussion with health promoters and the development of a national declaration (El Salvador), raising proposals from the grassroots (Guatemala) to increase awareness that has not been isolated but part of a movement with an international nature and which grassroots organisations were recognised by others.

However, not everything was positive. For some people there were difficult problems with the credibility of people leading this movement.

Evaluation of the Assembly

The Assembly was evaluated by the participants according to three considerations:

- The most relevant successes of the Assembly
- Aspects of the Assembly that are most memorable and that represent the strength of the movement
- Factors that were missing or could be improved in any future meetings

Relevant successes

The organisation of the Assembly

The fact that the Assembly happened is a huge result in itself: having a meeting of sympathetic organisation from the whole world, where the communities and poor people were an important presence. Holding the Assembly demonstrated the real capacity of mobilisation which these organisations have and the conviction that they are an important force.

The system for providing food showed the large measure of willingness to help and the solidarity of the organisations and people present.

Definition of the problem of health

The PHA was a unique opportunity to realise between diverse people unified lessons and approaches for action adapted to their particular realities. The Assembly also allowed holding an integral and integrated vision of health that led to a convergence of popular knowledge and practices.

Health was rescued as a fundamental right of the people, both collective and individual. The state of the health of the people is an expression of the social justice and social equity. Health is also a coodinating axis for social

organisations and movements which raise and explain the desire for a better world that has three fundamental pillars: peace, equality and sustainability. It recovered and reaffirmed Primary Health Care as a policy instrument and a way of working in community health.

Relations between the people and organisations

The Assembly was a real exchange of experience that was very motivating and permitted understanding of different health experiences in different parts of the world. In some cases it has extended links and relationships. The impact on the people at GK is significant: they feel supported and accompanies in their mission.

A space for denounciation

The Assembly was also a space to denounce very specific experiences of the domination of the USA over the people of the world (socioddramas from Japan and Brazil, and presentations from Mexico, Cuba, Palestine and others). Also it was possible to explore the mechanisms used by the World Bank and the IMF to apply exclusionary economic models in poor countries. Special attention was given to the WTO and particularly to the agreement over intellectual property rights.

An Assembly of proposals

One of the Assembly's most relevant results was the identification of those responsible for the application of the neo-liberal economic model, as well as of those who represent the *resistance* in poor countries. There was an opportunity for considering the role and space of popular organisations in the making of new proposals and the consideration of popular movements as one of the ways of taking action. There was also an opportunity for confirming the certainty that "the path we have chosen to follow, although hard, is the right one".

The Assembly became a call for all peoples around the world, something that materialized in the Declaration of the People's Health Assembly. Said document expresses how all the peoples –absent or present at the Assembly- feel, and represents the ideological foundations of the PHA. It also proposes the main guidelines for action and is considered the movement's credentials.

5.2 What must be maintained

The Assembly evidenced important aspects that are to be maintained and strengthened in upcoming world, regional and national meetings. For example, the presence of the community, the cultural meetings, the "presence of the peoples' voices", the "appreciation of each region's own culture as an expression of anti-homogenization", the "spirit of friendship and hope shown by coordinators and assumed by participants".

This has meant the consideration of the urgent need for developing actions towards maintaining the "communication and interrelations amongst the organisations", the "data interchange through the INTERNET", the "coordination of efforts in propelling actions beyond the areas already treated", the "coming together –both at continental and intercontinental levels- in order to share experiences", the need to create "spaces to share and transmit local and regional experiences and/or processes (resistances and sound proposals)".

Other relevant aspects mentioned were:

- Solidarity with grassroots groups
- International contact with positive relations between professionals and NGOs
- Presence of journalists working with the movement
- The hope against the avalanche of disillusions and frustrations
- Supporting and valuing popular education
- Promotion of the strength to change the systematically unfair structures
- Energy and motivation

What was missing?

There were no representatives of organisations (like the World Health Organisation) to hear the people's voices and show the importance given by participants to the presence of international health organisations.

Other aspects that were mentioned as important during the Assembly were:

- Lack of discussion of scientific and cultural paradigms
- Lack of time to understand more experiences through workshops and better organisation of the small workshops in the afternoon
- Lack of analysis of the Charter to make corrections. Not enough time.
- A greater presence of original Latin American peoples.
- More grassroots groups
- There were communication problems caused by language difficulties
- Not enough statements regarding traditional health systems and natural medicine

Progress since the Assembly

Participants of the Assembly and their organisations developed a series of activities with the purpose of sharing the results of the Assembly and the proposals made. In some cases, the activity has gone beyond the organisations by making the movement known in other areas such as academic, religious or political contexts, local (municipal) governments, etc.

An electronic communications network for the movement has been created at the Latin American regional level. Such network is quite useful in helping with relevant information and aids participants in making their presentations, in sharing news about meetings, in determining how to deal with the situation of 11 September, and in generating pressure (Brazil). The network started off with 54 members.

Guatemala. The Charter has been printed, distributed and included in several places: training of health promoters, bulletins and community newssheets. A summary of the Assembly has also been published and used to influence the Catholic Church, academics and the news media. The Assembly and its proposals have been included in institutional work.

Ecuador. Work with news media to make the Charter public. Placement of the Charter at different locations. Realisation of the second Forum of Popular Health where the experience of the Assembly was presented (October 2001).

El Salvador: Regional workshop to consider the proposals from the Assembly and the trade agreements (ALCA) and health sector reforms. Distribution of the proposals of the Assembly and definition of plans for 2002.

Mexico:

Distribution of the Charter. Promise to adapt it so that it can be understood by the communities; promise of translating it into Tzotzil

Meetings with municipal promoters where the Charter was distributed. Charter sent to the Zapatista movement

Distribution in the community of Coyoacan, through radio programmes, dissemination in the university

Argentina. Editing of an article for distribution in the media; radio programs with material recorded in Bangladesh; publication of an article on life in Bangladesh, preparation of an article in the Internet and a publication and workshop at Medical Congress.

Brazil: Local meetings with different organisations and parties involved, particularly with the communities (prefects, schools, political parties, trade unions) where the Charter was distributed

Nicaragua. A large meeting with the people who participated in the preparation of the Assembly to present the experience of the Assembly. Proposals and discussion.

The most impressive moment or aspect of the Assembly

- The moment when the Charter was read
- The presence of the people of Bangladesh
- The coordination and spirit of the meeting
- Hearing about the peoples' suffering, and the expression of hope
- The permanent joy
- The expression of solidarity with Cuba
- Understanding that individual stories are part of one only story

7. THE MOVEMENT'S SPECIFIC CONTRIBUTION

The Movement shows certain specific characteristics that make it different and supplemental to other movements and organisations working in different societies:

a. It is a call to **all** peoples for the creation and development of a **transforming power for society.** The movement is not exclusive; it convokes all peoples to constitute a force in order to create substantial changes in the different societies.

b. It is a **unifying** movement. It aims at the union of peoples to provide unified answers to their health problems.

c. It proposes a **different revolution**: the revolution of hope. It does not involve bloodshed but a battle with the strength of love for those who most suffer the consequences of an unfair society.

d. It is a solidarity movement.

e. It struggles for the **dignity of people.**

f. It is a movement **rooted in the community.**

g. It shakes **awareness.**

h. It generates a **sense of belonging**. It offers participants the possibility of becoming part of a great movement of social transformation. Participants do not feel isolated but coordinated with common purposes.

It is a movement that convokes all peoples of the world from their community roots, it shakes awareness and coordinates efforts with a common purpose in order to produce substantial transformations in society, without violence but in a solidaristic and loving manner with and among those who suffer, so as to jointly react to the severe health problems and with the objective of saving the dignity of people.

8. WHAT IS TO BE DONE?

g. It is necessary to make an auto-critical analysis regarding our own social responsibility in abandoning popular proposals and taking up agendas that respond to other interests not oriented at achieving health and well-being of people.

c. It is a must for all those involved with the movement and its proposals to join efforts by taking as a fact health as: a subject to bring together the will of individuals, a political issue, a transforming power.

d. To bring NGOs and universities into a compromise.

d. To strengthen and concentrate work at a local level (for example, at a municipal level).

e. To generate, within communities, the ability to act in their social context, and to provide the appropriate tools.

f. To administer, supervise and control the State's actions.

g. To strengthen the relationship among base organisations.

h. To redefine the role of NGOs and other organisations as intermediaries.

i. To establish links with international cooperation so as to have it as support for popular initiatives.

> From our Latin American perspective, we dream of a world in which people may live with dignity, without humiliations or discriminations, and where health may be an expression of that humane and popular and people may regain their right to joy and happiness.
> We hope for our peoples to conquer the will for battle and hope again. We take ourselves as belonging to nature as a whole, where we are bound to create the necessary conditions of harmony and respectfulness. Also in hope of exercising our power to create a world where there is space for many worlds to live in justice, equity, peace and happiness.

9. EVALUATION OF THE MEETING

Participants stated the relevance of methodology for achieving the purposed set forth. It was admitted that the meeting provided the opportunity for everyone to express their ideas and feelings and to make the proposals they considered appropriate. However, the lack of communication techniques is

acknowledged as something that otherwise could have made the meeting more productive. See Annex for quoted expressions of participants.

ANNEX 1

DECEMBER MEETING OF PHA -EXCHANGE
DECEMBER 4 TO 7, 2001.

LIST OF PARTICIPANTS

Nr.	NAME AND ORGANISATION	e-mail
1	Julio Monsalvo	altaalegremia@hotmail.com
2	Ani Whibey	Acwlepalis@aol.com
3	Arturo Quizphe	**iphc,sa@etapa.com.ec**
4	Margarita Posada	aprocsal@navegante.com
5	María Hamlin Zúniga	iphc@cisas.org.ni
6	Hugo Icú	asecsa@guate.net
7	Aida Peralta	hildadavid@mexis.com aida_peralta@hotmail.com
8	Gabriel García	mecano99@prodigy.net.mx winiketik@hotmail.com juatik@prodigy.net.mx
9	Carolina Grajales	carolina_grajales@infosel.net.mx
10	Blanca Cajina	Asprodic@sdnnic.org.ni
11	Denisse Was mann	Kampura@sdnnic.org.ni
12	Darlena David	darlena@hesperian.org
13	Andrew Chetley	
14	Jesús Roberto López Linares	ais@amauta.rcp.net.pe

Individuals invited who did not attend the meeting

Nr.	NOMBRE Y ORGANISMO	REASONS FOR NOT ATTENDING
1	Eduardo Espinoza espinoza@telesal.net	Meeting with El Salvador's Legislative Assembly in defence of the University of El Salvador's budget.
2	Nadine Gasman nadineg@supernet.com.mx	Previous appointments for dates involved.
3	Mario Cabrera mario_cb@hotmail.com	Not authorized to attend by the Ministry of Health of Costa Rica.
4	Reyna Cordero Rcordero@amc.org..ni	Working reasons (floods at the Atlantic Coast) could not attend.
5	René Pérez (CIES) Rperezmontiel@yahoo.com	Unknown.

ANNEX 2

EVALUATION OF MEETING

Contents

a. The work previous to and following the Assembly mentioned by each of the participants was enough to inspire and appreciate the effort of each individual and group involved. It was enough for understanding the meaning of collective effort!
The story is important – apart from the contents, it offers a path to be taken and share experiences and appreciate those of others. Each person's work was valued.
The concepts about processes and "moving towards the future" were collectively obtained and the group that redacted the subject to be considered deserves to be congratulated.

b. The contents were based on the purpose of the meeting and each subject had an in-depth consideration. They were widely treated and that happened before, during and after the PHA. The idea was to "land" on a specific proposal.

c. The main considerations were centred on our life-experience, thoughts and actions since we became involved with anything relating to PHA. The interchange seemed to me very rich in allowing knowledge of what every one, as a person or group, was able to carry out. The dreaming exercise seemed to me very vital, since it gave us the opportunity to re-create our hopes. Each experience shown has been enriching for what we do in our own places.

d. Excellent there was a space to share, analyse and plan.

e. We reflected upon theory and practice, which allowed us to arrive to praxis.

f. Ample, comprehensive, provided space for suggesting other topics.

g. Acceptable level. Allows for identification and conceptualisation.

h. Interesting, very much related, reflects the diversity of that region.

i. Close relationship with the meeting's overall objective.

j. I considered this meeting necessary, since there was an urge to know what was happening in America with the piers that were with us in Bangladesh, as well as our difficulties, obstacles and advances. It is important to share experiences about the work being done in our countries, the level of knowledge of the population and of various organisations in regards to their awareness of the Declaration of Bangladesh. I also think we were leaving the

subject of environment aside. I think the draft we analysed was quite good, but subject to changes since it is dynamic and depends on different considerations.

Commitments

a. Each person's energy, knowledge and will evidenced the individual and collective commitments. Each one is undoubtedly committed with the Movement.

b. The presence of certain individuals opened a way to a better understanding of the meaning of a more profound commitment. This brings joy and hope; there is no lack of commitment. 100%.

c. Some committed themselves to participate actively in the PHM, by distributing the declaration at the community level and by generating the abilities and strengths needed to distribute the information in the Net.

d. Continue to distribute the Declaration, finish the translation into tzotzil and look for the ways of translating it into tzeltal and tojolabal. Involve the groups close to our work in the progress of the Movement.

e. To strengthen the Latin American network and share local and national information as well as synthesise experiences.

f. To create and/or strengthen the PHA at local, regional and international levels. To distribute the PHA's Declaration in our activity. To maintain the compromise, the resistance and the struggle for the right to being healthy. Reaction and pronouncement against actions that contravene people's health.

g. The motivation is quite evident. Maybe the definition of certain specific activities to be performed together with, or "bilaterally".

h. Emphasise and make known the construction process of this movement. Keep communicated. Get other individuals, organisations and related groups involved.

i. Consolidate the promotion and distribution of PHA's Declaration in the communities where we work. Have an incidence on making the various health agents sensible to searching for alternative solutions for the various health problems mentioned in the Declaration, by means of the active participation of different local sectors. Continue with permanent communication with our partner (s) in the movement. Exchange experiences with the others regarding the work done in our areas.

Methodology

j. Despite the lack of certain techniques during the working days, the process maintained a progressive line from beginning to end, which was logical, and for each stage of the work.

Each individual's story, effort and process (whatever country they were from) showed that up to now, the movement makes sense and is worthy.

Methodology: the methodology used allowed an understanding of what coordinators wanted. Some techniques and dynamics that could have optimised the objectives achieved were not available.

k. It was good in the sense that it was open and flexible, but considering the small size of the group and the high preparation of its members, it turned out too formal and restrictive. I though it appropriate, productive and "wringing out". Even the jokes were on the topic.

l. It allowed everyone's participation. There was a lack of a pre-meeting guide to work with so as to get into the subject more profoundly and be able to expose ideas and proposals more clearly.

m. The methodology was very participative and reflexive.

n. At first (Tuesday) it was useful for remembering the life experience of a year ago and the actions taken in the meantime. Dividing the process in stages allowed a place for our feelings and perceptions. The facilitator rounded up with an idea that summarized what was said and developed during the meeting and what was expressed in each stage, thus allowing for the next stage. We were all free to express ourselves in time.

o. Time enough for each topic. Constant interest. Good conduction. There was always the will to specify.

p. It thought it excellent, since it allowed the active participation of all those present, sharing the various ideas, reflections, discussions and proposals. The opening was quite good as well as the facilitator's dynamism, his due contributions and his management of such a wide topic.

q. Appropriate for the objectives and contents. Good interrelation and communication. Creation of an alternative vision and option (Synthesis).

r. Excellent. Very good distribution of time. The working atmosphere was relaxed. A reason for participating.

ANNEX 3:

THE WORLD OF OUR DREAMS

We would like a world where:

- the economic model is focused on the people and not on productivity or profits.
- people take part in the making of decisions to achieve equity and equality.
- we may all have the right to determine our own life.
- the model that produces disease has been overcome.
- there are no hospitals.
- life is lived with dignity and without humiliation or discrimination.
- the mass media reveal the truth.
- people are sensible and take action and there is no apathy.
- life is worth living.
- fairness and happiness are present.
- technology is mastered and used to serve all men and women.
- power is exercised to bring about benefits that benefit all.
- human beings live together in harmony and in balance with nature.
- the will for struggling and hope is regained.
- health is an expression of that humane and popular.

Apendix 5: Summary Report - People's Health Movement (PHM)
East and Central Africa Region Workshop
Dar es Salaam, Tanzania, 29 Apr – 2 May 2002

Seventeen participants from six countries took part in the first regional workshop of the People's Health Movement (PHM) in Africa. The aims of the workshop were to

- reflect on the experience of the People's Health Assembly (PHA) – held in Savar, Bangladesh in December 2000 – including the way the People's Health Charter can be used to help strengthen health activities and systems in Africa and campaign for greater support for comprehensive primary health care (PHC). (The concept of comprehensive primary health care was first articulated at an international conference in Alma-Ata in 1978.)
- identify key health issues that are important for people in Africa
- strengthen the work of the People's Health Movement in Africa.

During the four-day meeting, participants:

- developed an interim coordinating circle for PHM activities in Kenya, Tanzania, Uganda and Zimbabwe that will work to expand involvement of other organisations, institutions and networks in those countries, and to reach out to other countries in the region and elsewhere in Africa
- confirmed support for the People's Health Charter and identified several areas within it that were a particular focus for Africa at the present time
- welcomed the availability of a draft version of the Charter in Swahili and confirmed the need to encourage the development of other language versions to ensure greater awareness of the issues raised in the Charter
- reaffimed PHM's commitment to listen to and work with grassroots people and organisations and to provide opportunities and spaces for their voices to be heard, listened to, and acted upon by policy and decision makers
- planned for a larger follow-up workshop in September 2002, in conjunction with a series of training and information workshops that the Africa PHM will hold as part of the World Alliance for Breastfeeding Action (WABA) global forum in Arusha, Tanzania
- identified issues to raise at a series of PHM meetings planned at the 2002 World Health Assembly (WHA) in Geneva in May – both to inform government delegates at the WHA and to discuss with colleagues within the PHM from other regions.

The workshop was opened by Dr Upunda G. L., Chief Medical Officer on behalf of the Permanent Secretary for the Ministry of Health, Tanzania. Dr Upunda said that 'primary health care was and still is the correct pathway for us all'. He said holding such a meeting in East Africa was 'bringing the agenda home'. He challenged the participants, and included himself and the government in the challenge, by asking: 'Do our plans allow for our communities to re-strategise when things go wrong? Do we give them that opportunity? Let's listen to these communities. Do we? Do we? How many times do we allow them to be part of their development?'

He said that *'genuine people-centred initiatives must be strengthened to increase pressure on decision-makers, governments and the private sector to ensure that the vision of Alma-Ata becomes a reality'.*

During the meeting, Mwajuma Masaiganah from Tanzania, who was selected as the interim regional coordinator, responded to the challenge issued by Dr Upunda by noting that 'As non-governmental organisations (NGOs), we may not have been keen enough to let power go to the people, and have maintained the status quo. We should consider ourselves as a movement, a group that pressures and leads a people-centred process.'

Participants reviewed and discussed the health issues in Africa, looking at the range of disease conditions and the social, political and economic determinants that affect people's health. Among the diseases highlighted were:

- HIV/AIDS
- TB – increasing partly due to HIV
- Ebola fever
- Malaria – increased drug resistance
- Typhoid fever
- Cholera
- Measles.

Participants stressed that HIV/AIDS was a serious problem for health in Africa, but not the only problem, and that it was important to look at the context and ensure that sufficient resources are available to prevent and treat other leading diseases.

The social, political and economic determinants that were impacting on health and that needed to be considered were identified as:

- Structural adjustment programmes
- Trade-related intellectual property rights (TRIPs)
- Corruption – which impacts at every level: bribes sometimes have to be paid just to see a health worker
- Gender insensitivity - increases the disparity in access to health services. The health system tends to be gender blind
- Conflicts and wars
- Gender violence
- Cultural beliefs and practices – particularly affecting sexual and reproductive health
- Environmental issues – including water and sanitation, deforestation and natural disasters
- Lack of basic infrastructure – transport, deterioration of the health system, including lack of quality services.

Participants discussed a range of cultural beliefs and practices that contribute to poor health and increase the risk of disease. They also identified some practices that were helpful in strengthening healthy behaviour. They recognised the need to support and encourage positive practices, while working towards changing or eliminating those that impact adversely on health.

Participants identified the need for pro-active strategies and the need to increase critical thinking among communities, so that they could play a stronger role in finding their own solutions to health concerns and would be empowered to take action to demand their rights.

A key link in this process was the need to develop partnerships with local and national governments, to complement their work and strengthen their ability to provide services that people need. Governments should help peoples' organisations, including the PHM, to be recognised and represented at decision making forums where issues affecting health are discussed, and to facilitate their recognition and support from national and international donors as channels for resources to facilitate the process of grassroots involvement.

The People's Health Charter was seen as a useful tool to help in a people-centred process of mobilisation and awareness building at the grassroots level. The PHM should work hand in hand with existing public health care committees at the grassroots level. Communicating the issues expressed in the Charter is a way of breaking the silence around many of these health concerns and strengthening peoples' ability to be involved in the process of both contributing to and demanding the development and strengthening of relevant and effective health services.

Particular attention needs to be paid to engendering the process so that gender specific needs are considered and communicated at every step – from planning, resourcing, implementing, and monitoring and evaluation of the process.

Participants identified the role of the PHM in Africa as being that of a strong unifying force, helping to bring together many of the people and organisations involved in effective initiatives to improve health. Interim national coordinators were selected to help with this. They are:

- Tanzania: Mathew Kimario
- Kenya: Malachi Orondo
- Uganda: Alice Drito
- Zimbabwe: Mary Sandasi.

A full report of the proceedings will be available by the end of June 2002

Appendix 6: List of documents reviewed

1) Planning Meetings Reports People's Health Assembly

- First Planning Meeting : 5th.- 9th. November -1998 - Malaysia
- Second Planning Meeting: 2 - 4 March 1999 - Malaysia
- Third Planning Meeting : 4-7 September- 1992 – Savar, Bangladesh
- Four Planning Meeting : 10-13 March – 2000-Penang / Malaysia
- Fifth Planning Meeting : ??? July - 2000 - Penang / Malaysia
- Report on Analytical Group:

2) Background Papers

- PHA: Health in the Era of Globalisation, from victims to protagonists- Discussion Paper prepared by the PHA Drafting Group.

- Background Papers:

  The Political Economy of the Assault on Health *by Mohan Rao and Rene Loewenson*
  Equity and Inequity today, some contributing social factors *by Nadine Gasman and Maxine Hart*
  The Medicalization of Health Care and the Challenge of Health for All, *by David Sanders*
  The Environmental Crisis, Threats to Health and Ways Forward, *by Niclas Hallstrom*
  Communicationas if People Mattered, adapting health promotion and social action on the global imbalances of the 21st century *by David Werner.*

- People's Charter for Health - PHA

3) Reports:

- Report on the activities of National Preparatory Committee, Nepal, for People's Health Assembly (PHA 2000) Savar, Bangladesh / 4/8 December, 2000 – December 2000. National Secretariat of national preparatory Committee for PHA 2000- Ressource centre for Primary Health Care.
- People's Health Assembly 2000: Report up to 31st. March 2001- PHA Gonoshasthaya Kendra, Savar, Dhaka.
- "We have created history" The People's health assembly: speaking from the heart – Report to One World Action- Andrew Chetley- March 2001.
- PHA Secretariat, Savar – December 3 rd. 2001

- Regional Evaluation Report : LatinAmerica - Managua, Nicaragua, 4 / 6 December 2001

- Regional Evaluation Report: Africa – Dar es Salaam, Tanzania- 29 Aril-2 May 2002
- Communication VI PHM Secretariat after WHA 2003.

4) People's Health Assembly: Project Proposal

5) PHA India Chapter Preparation / Report

6) People s Verdict on Health - Report Physician at FRLHT

7) PHA Coordinating Group Meeting- 9 December 2000

8) Notes : Tasks, PHA Notes – Dec. 2000 / Dec. 2001 PHA Follow up, Savar 4-8 December.

9) ASSERT- Health and Safety- Institute for Occupational Health & Safety Development (IOHSAD) Philippines- VOL 12 N 1 – July December 2000.

10) PHA Secretariat Meeting Report, Savar, October 30th.2001

11) Meeting Minutes: PHA representatives meeting with Dr. Gro Harlem Brundtland (18/05/01)

12) Coordinators Report from PHM Secretariat. PHM Core Group Meeting: 20-22 Gonashasthaya, Kendra, Savar, Dhaka,Bangladesh ,November 2002.

13) People s Health in People' s Hands. Vision for PHM – Geneva 2002.

14) A People s Charter for Health & Beyond.

15) Collection of case Studies, Testimonies & Stories.

16) PHM website; IPHC website

Appendix 7 – The People's Health Charter

PEOPLE'S CHARTER FOR HEALTH

PREAMBLE
Health is a social, economic and political issue and above all a fundamental human right. Inequality, poverty, exploitation, violence and injustice are at the root of ill-health and the deaths of poor and marginalised people. Health for all means that powerful interests have to be challenged, that globalisation has to be opposed, and that political and economic priorities have to be drastically changed.

This Charter builds on perspectives of people whose voices have rarely been heard before, if at all. It encourages people to develop their own solutions and to hold accountable local authorities, national governments, international organisations and corporations.

VISION
Equity, ecologically-sustainable development and peace are at the heart of our vision of a better world - a world in which a healthy life for all is a reality; a world that respects, appreciates and celebrates all life and diversity; a world that enables the flowering of people's talents and abilities to enrich each other; a world in which people's voices guide the decisions that shape our lives.

There are more than enough resources to achieve this vision.

THE HEALTH CRISIS
"Illness and death every day anger us. Not because there are people who get sick or because there are people who die. We are angry because many illnesses and deaths have their roots in the economic and social policies that are imposed on us."
(A voice from Central America)

In recent decades, economic changes world-wide have profoundly affected people's health and their access to health care and other social services.

Despite unprecedented levels of wealth in the world, poverty and hunger are increasing. The gap between rich and poor nations has widened, as have inequalities within countries, between social classes, between men and women and between young and old.

A large proportion of the world's population still lacks access to food, education, safe drinking water, sanitation, shelter, land and its resources, employment and health care services. Discrimination continues to prevail. It affects both the occurrence of disease and access to health care.

The planet's natural resources are being depleted at an alarming rate. The resulting degradation of the environment threatens everyone's health, especially the health of the poor. There has been an upsurge of new conflicts while weapons of mass destruction still pose a grave threat.

The world's resources are increasingly concentrated in the hands of a few who strive to maximise their private profit. Neoliberal political and economic policies are made by a small group of powerful governments, and by international institutions such as the World Bank, the International Monetary Fund and the World Trade Organisation. These policies, together with the unregulated activities of transnational corporations, have had severe effects on the lives and livelihoods, health and well-being of people in both North and South.

Public services are not fulfilling people's needs, not least because they have deteriorated as a result of cuts in governments' social budgets. Health services have become less accessible, more unevenly distributed and more inappropriate.

Privatisation threatens to undermine access to health care still further and to compromise the essential principle of equity. The persistence of preventable ill health, the resurgence of diseases such as tuberculosis and malaria, and the emergence and spread of new diseases such as HIV/AIDS are a stark reminder of our world's lack of commitment to principles of equity and justice.

PRINCIPLES OF THE PEOPLE'S CHARTER FOR HEALTH

- The attainment of the highest possible level of health and well-being is a fundamental human right, regardless of a person's colour, ethnic background, religion, gender, age, abilities, sexual orientation or class.
- The principles of universal, comprehensive Primary Health Care (PHC), envisioned in the 1978 Alma Ata Declaration, should be the basis for formulating policies related to health. Now more than ever an equitable, participatory and intersectoral approach to health and health care is needed.
- Governments have a fundamental responsibility to ensure universal access to quality health care, education and other social services according to people's needs, not according to their ability to pay.
- The participation of people and people's organisations is essential to the formulation, implementation and evaluation of all health and social policies and programmes.
- Health is primarily determined by the political, economic, social and physical environment and should, along with equity and sustainable development, be a top priority in local, national and international policy-making.

A CALL FOR ACTION

To combat the global health crisis, we need to take action at all levels - individual, community, national, regional and global - and in all sectors. The demands presented below provide a basis for action.

HEALTH AS A HUMAN RIGHT

Health is a reflection of a society's commitment to equity and justice. Health and human rights should prevail over economic and political concerns.

This Charter calls on people of the world to:

- Support all attempts to implement the right to health.
- Demand that governments and international organisations reformulate, implement and enforce policies and practices which respect the right to health.
- Build broad-based popular movements to pressure governments to incorporate health and human rights into national constitutions and legislation.
- Fight the exploitation of people's health needs for purposes of profit.

TACKLING THE BROADER DETERMINANTS OF HEALTH

Economic challenges

The economy has a profound influence on people's health. Economic policies that prioritise equity, health and social well-being can improve the health of the people as well as the economy.

Political, financial, agricultural and industrial policies which respond primarily to capitalist needs, imposed by national governments and international organisations, alienate people from their lives and livelihoods. The processes of economic globalisation and liberalisation have increased inequalities between and within nations.

Many countries of the world and especially the most powerful ones are using their resources,

including economic sanctions and military interventions, to consolidate and expand their positions, with devastating effects on people's lives.

This Charter calls on people of the world to:

- Demand transformation of the World Trade Organisation and the global trading system so that it ceases to violate social, environmental, economic and health rights of people and begins to discriminate positively in favour of countries of the South. In order to protect public health, such transformation must include intellectual property regimes such as patents and the Trade Related aspects of Intellectual Property Rights (TRIPS) agreement.
- Demand the cancellation of Third World debt.
- Demand radical transformation of the World Bank and International Monetary Fund so that these institutions reflect and actively promote the rights and interests of developing countries.
- Demand effective regulation to ensure that TNCs do not have negative effects on people's health, exploit their workforce, degrade the environment or impinge on national sovereignty.
- Ensure that governments implement agricultural policies attuned to people's needs and not to the demands of the market, thereby guaranteeing food security and equitable access to food.
- Demand that national governments act to protect public health rights in intellectual property laws.
- Demand the control and taxation of speculative international capital flows.
- Insist that all economic policies be subject to health, equity, gender and environmental impact assessments and include enforceable regulatory measures to ensure compliance.
- Challenge growth-centred economic theories and replace them with alternatives that create humane and sustainable societies. Economic theories should recognise environmental constraints, the fundamental importance of equity and health, and the contribution of unpaid labour, especially the unrecognised work of women.

Social and political challenges

Comprehensive social policies have positive effects on people's lives and livelihoods. Economic globalisation and privatisation have profoundly disrupted communities, families and cultures. Women are essential to sustaining the social fabric of societies everywhere, yet their basic needs are often ignored or denied, and their rights and persons violated.

Public institutions have been undermined and weakened. Many of their responsibilities have been transferred to the private sector, particularly corporations, or to other national and international institutions, which are rarely accountable to the people. Furthermore, the power of political parties and trade unions has been severely curtailed, while conservative and fundamentalist forces are on the rise. Participatory democracy in political organisations and civic structures should thrive. There is an urgent need to foster and ensure transparency and accountability.

This Charter calls on people of the world to:

- Demand and support the development and implementation of comprehensive social policies with full participation of people.
- Ensure that all women and all men have equal rights to work, livelihoods, to freedom of expression, to political participation, to exercise religious choice, to education and to freedom from violence.

- Pressure governments to introduce and enforce legislation to protect and promote the physical, mental and spiritual health and human rights of marginalised groups.
- Demand that education and health are placed at the top of the political agenda. This calls for free and compulsory quality education for all children and adults, particularly girl children and women, and for quality early childhood education and care.
- Demand that the activities of public institutions, such as child care services, food distribution systems, and housing provisions, benefit the health of individuals and communities.
- Condemn and seek the reversal of any policies, which result in the forced displacement of people from their lands, homes or jobs.
- Oppose fundamentalist forces that threaten the rights and liberties of individuals, particularly the lives of women, children and minorities.
- Oppose sex tourism and the global traffic of women and children.

Environmental challenges

Water and air pollution, rapid climate change, ozone layer depletion, nuclear energy and waste, toxic chemicals and pesticides, loss of biodiversity, deforestation and soil erosion have far-reaching effects on people's health. The root causes of this destruction include the unsustainable exploitation of natural resources, the absence of a long-term holistic vision, the spread of individualistic and profit-maximising behaviours, and over-consumption by the rich. This destruction must be confronted and reversed immediately and effectively.

This Charter calls on people of the world to:

- Hold transnational and national corporations, public institutions and the military accountable for their destructive and hazardous activities that impact on the environment and people's health.
- Demand that all development projects be evaluated against health and environmental criteria and that caution and restraint be applied whenever technologies or policies pose potential threats to health and the environment (the precautionary principle).
- Demand that governments rapidly commit themselves to reductions of greenhouse gases from their own territories far stricter than those set out in the international climate change agreement, without resorting to hazardous or inappropriate technologies and practices.
- Oppose the shifting of hazardous industries and toxic and radioactive waste to poorer countries and marginalised communities and encourage solutions that minimise waste production.
- Reduce over-consumption and non-sustainable lifestyles - both in the North and the South. Pressure wealthy industrialised countries to reduce their consumption and pollution by 90 per cent.
- Demand measures to ensure occupational health and safety, including worker-centred monitoring of working conditions.
- Demand measures to prevent accidents and injuries in the workplace, the community and in homes.
- Reject patents on life and oppose bio-piracy of traditional and indigenous knowledge and resources.
- Develop people-centred, community-based indicators of environmental and social progress, and to press for the development and adoption of regular audits that measure environmental degradation and the health status of the population.

War, violence, conflict and natural disasters

War, violence, conflict and natural disasters devastate communities and destroy human dignity. They have a severe impact on the physical and mental health of their members, especially women and children. Increased arms procurement and an aggressive and corrupt international arms trade undermine social, political and economic stability and the allocation of resources to the social sector.

This Charter calls on people of the world to:

- Support campaigns and movements for peace and disarmament.
- Support campaigns against aggression, and the research, production, testing and use of weapons of mass destruction and other arms, including all types of landmines.
- Support people's initiatives to achieve a just and lasting peace, especially in countries with experiences of civil war and genocide.
- Condemn the use of child soldiers, and the abuse and rape, torture and killing of women and children.
- Demand the end of occupation as one of the most destructive tools to human dignity.
- Oppose the militarisation of humanitarian relief interventions.
- Demand the radical transformation of the UN Security Council so that it functions democratically.
- Demand that the United Nations and individual states end all kinds of sanctions used as an instrument of aggression which can damage the health of civilian populations.
- Encourage independent, people-based initiatives to declare neighbourhoods, communities and cities areas of peace and zones free of weapons.
- Support actions and campaigns for the prevention and reduction of aggressive and violent behaviour, especially in men, and the fostering of peaceful coexistence.
- Support actions and campaigns for the prevention of natural disasters and the reduction of subsequent human suffering.

A PEOPLE-CENTERED HEALTH SECTOR

This Charter calls for the provision of universal and comprehensive primary health care, irrespective of people's ability to pay. Health services must be democratic and accountable with sufficient resources to achieve this.

This Charter calls on people of the world to:

- Oppose international and national policies that privatise health care and turn it into a commodity.
- Demand that governments promote, finance and provide comprehensive Primary Health Care as the most effective way of addressing health problems and organising public health services so as to ensure free and universal access.
- Pressure governments to adopt, implement and enforce national health and drugs policies.
- Demand that governments oppose the privatisation of public health services and ensure effective regulation of the private medical sector, including charitable and NGO medical services.
- Demand a radical transformation of the World Health Organization (WHO) so that it responds to health challenges in a manner which benefits the poor, avoids vertical approaches, ensures intersectoral work, involves people's organisations in the World Health Assembly, and ensures independence from corporate interests.
- Promote, support and engage in actions that encourage people's power and control in decision-making in health at all levels, including patient and consumer rights.

- Support, recognise and promote traditional and holistic healing systems and practitioners and their integration into Primary Health Care.
- Demand changes in the training of health personnel so that they become more problem-oriented and practice-based, understand better the impact of global issues in their communities, and are encouraged to work with and respect the community and its diversities.
- Demystify medical and health technologies (including medicines) and demand that they be subordinated to the health needs of the people.
- Demand that research in health, including genetic research and the development of medicines and reproductive technologies, is carried out in a participatory, needs-based manner by accountable institutions. It should be people- and public health-oriented, respecting universal ethical principles.
- Support people's rights to reproductive and sexual self-determination and oppose all coercive measures in population and family planning policies. This support includes the right to the full range of safe and effective methods of fertility regulation.

PEOPLE'S PARTICIPATION FOR A HEALTHY WORLD

Strong people's organisations and movements are fundamental to more democratic, transparent and accountable decision-making processes. It is essential that people's civil, political, economic, social and cultural rights are ensured. While governments have the primary responsibility for promoting a more equitable approach to health and human rights, a wide range of civil society groups and movements, and the media have an important role to play in ensuring people's power and control in policy development and in the monitoring of its implementation.

This Charter calls on people of the world to:

- Build and strengthen people's organisations to create a basis for analysis and action.
- Promote, support and engage in actions that encourage people's involvement in decision-making in public services at all levels.
- Demand that people's organisations be represented in local, national and international fora that are relevant to health.
- Support local initiatives towards participatory democracy through the establishment of people-centred solidarity networks across the world.

The People's Health Assembly and the Charter

The idea of a People's Health Assembly (PHA) has been discussed for more than a decade. In 1998 a number of organisations launched the PHA process and started to plan a large international Assembly meeting, held in Bangladesh at the end of 2000. A range of pre- and post-Assembly activities were initiated including regional workshops, the collection of people's health-related stories and the drafting of a People's Charter for Health

The present Charter builds upon the views of citizens and people's organisations from around the world, and was first approved and opened for endorsement at the Assembly meeting in Savar, Bangladesh, in December 2000.

The Charter is an expression of our common concerns, our vision of a better and healthier world, and of our calls for radical action. It is a tool for advocacy and a rallying point around which a global health moment can gather and other networks and coalitions can be formed.

Join Us - Endorse the Charter

We call upon all individuals and organisations to join this global movement and invite you to endorse and help implement the People's Charter for Health

PHA Secretariat, e-mail: phasec@pha2000.org www.pha2000.org

Amendment
After the endorsement of the PCH on December 8, 2000, it was called to the attention fo the drafting group that action points number 1 and 2 under Economic challenges could be interpreted as supporting the social clause proposed by WTO, which actually serves to strengthen the WTO and its neoliberal agenda. Given that this countervails the PHA demands for change of the WTO and the global trading system, the two paragraphs were merged and amended.

The section of War, Violence and Conflict has been amended to include natural disasters. A new action point, number 5 in this version, was added to demand the end of occupation. Furthermore, action point number 7, now number 8, was amended to read to end all kinds of sanctions. An additional action point number 11 was added concerning natural disasters.

Appendix 8: Memories and echoes

Several local workmen were laying bricks in fresh cement at the entrance to a purpose-built conference facility at Gonoshasthaya Kendra (People's Health Centre), in Savar, Bangladesh. It was Sunday morning, 3 December 2000. Around them milled newly arrived people from more than 90 countries in Africa, Asia, Latin America, the Pacific, Europe, North America.

The air was filled with conversation in dozens of languages, as people found old friends, made new acquaintances, and sought out the location of the relevant registration desk. This was the day before the start of a unique five-day event: the People's Health Assembly (PHA).

Later than afternoon, hundreds of international delegates to the PHA at Savar walked to the nearby site of the Jyotir Sriti Soud – Bangladesh's national monument in honour of the heroes of its Liberation War in 1971.

And in the same spirit as that of the Martyrs the PHA participants pledged to fight until the noble goal of providing Health for All was achieved throughout the world. Arabs, Africans, Europeans, Americans and Asians joined together to make the people's health movement a truly global one.

Selvi, a health worker from the southern Indian state of Tamil Nadu, who had travelled by foot, by bus, by train and then by bus again to get to the PHA said, 'We are excited about the PHA. We are hopeful that this historic event will help to strengthen our spirits and solidarity'.

On the first day of the People's Health Assembly, as the custom-built hall began to fill with people, all the minor hiccups and frustrations participants were having in finding accommodation, locating where to have breakfast, finding out what to do about missing luggage, working out where to change money, and trying to discover what was going to happen next began to fade. In their place came a sense of excitement, of anticipation, of a desire to take up the challenge of improving people's health now and in the future.

Throughout the week, reality was never far away. Each morning, participants could see the young children making their way to the primary school within the compound at Gonoshasthaya Kendra, and watch them at play or doing their exercises. Food during the Assembly was supplied by women's groups from neighbouring villages who worked in temporary kitchens quickly constructed from bamboo to provide a nutritious and varied diet for everyone. The main eating area was outdoors in a quadrant bordered by the bamboo huts that were the kitchen space.

On day two of the PHA, a young village health worker from Nepal enacted for everyone the plight of a young woman who was typical of many she worked with in villages. She was in bonded labour, had no food, no money. Her husband had died. Now, in order to feed her child, she would have to offer her into bonded labour. How could she put her daughter through the misery that she had faced all her life? Her final, impassioned cry was 'God help me or let me die.'

Thelma Narayan from India responded to this by adding that the story reflected the situation of millions of women in Asia and highlighted the gender inequality of poverty and ill health. 'It is the suffering that moves us,' she said. 'Our anger at the injustice has led us to develop strategies to cope. What we are recognising is that this is a global phenomenon and therefore the response needs to be global. We need to address the issue of power and to look at how power affects the lives of people. It is our role to influence those who hold power.'

Boshi Mohlala from South Africa compared the phenomenon of globalisation to that of slavery. He asked 'why did it take so long - 300 years - to end the slave trade? Why did it take so long to stop colonisation? Why is the world organised the way it is?' Each 'why' was said slowly, softly, meaningfully, and it seemed to resonate around the hall, encouraging reflection. The answer he offered was that 'somewhere, someone decides not to do something about it. Enough is enough. We cannot allow globalisation to go on. Let's stop the multinational corporations and the World Bank policies now. Let us stop poverty and inequality now!'

The early morning mist had barely lifted on the third day as participants from India began circulating to have a few words with other participants who were having their breakfast. They talked to as many people as they could, and explained that late into the night, the Indian participants had been discussing what position to take over the planned address to the PHA by a representative from the World Bank, Richard Lee Skolnik. The conclusion they came to was that the World Bank had no right to be at a People's Health Assembly. They were informing everybody of their plans to stage a peaceful protest.

As the appointed time for the session drew near, the hall was full to bursting and a strong tingle of excitement and anticipation crackled like electricity through the atmosphere. There was a whisper of surprise when Dr B Ekbal, one of the leading Indian participants, took the chair for the session. He said that the session would not be looking at abstract policies but was an opportunity to tell some real life stories about the impact of World Bank policies on people's health. He said that there was legitimate protest and concern on the part of some of the participants about the Bank being present. He then called on the Indian participants to make an initial, small protest.

It began as a few small, clear voices singing and chanting, 'World Bank: no chance' and 'World Bank, down, down, down'. Soon, the rhythmic clapping and chanting was surging throughout the audience, a powerful and defiant roar.

Richard Lee Skolnik, Regional Director for Health, Nutrition and Population for South Asia at the World Bank, watched the protest impassively. Then, Dr Ekbal called for order. There were some continued protests stating that 'we do not want to hear'. However, others in the audience said, 'we want to listen'. Two members of the organising group – Ravi Nayaran from India, and Claudio Shuftan from Chile – called for the protesters to let the session continue.

It began with presentations from Mary Sandasi from Zimbabwe and Hugo Icu from Guatemala.

Mary Sandasi used a quilt developed by women's organisations that illustrated the headlines that reflected the impact of structural adjustment policies. Issues such as the increase in the price of bread and other essential foods, disintegration of health services, loss of land, increased sex work by women, increased sexually transmitted diseases and the spread of HIV/AIDS were all seen as outcomes.

Hugo Icu explained that health sector reform in Guatemala meant that 40 per cent of the population lack access to health care. He said that the structural reform process had deprived the Guatemalan people of their right to health.

After each of these interventions, there was a reprise of the 'World Bank: no chance' chant. As the floor was about to be turned over to Richard Skolnik, the protests built again, filling the room with singing, chanting and clapping. Zafrullah Chowdhury, Director of Programmes at Gonoshasthaya Kendra, and Prem John, from India, called on the participants to let the Bank speak. In the end, Skolnik was able to speak.

On the morning of the final day of the Assembly, 61 people (34 women and 27 men) from 24 countries took to the floor to offer suggestions of how the momentum generated by the pre-Assembly activities and by the Assembly itself could be taken forward in a global movement.

A couple of hours later, six people representing different parts of the world, read out the sections of the People's Charter for Health. The Assembly endorsed it, and people began to sign banners signifying their endorsement.

Nearly a year later, a small planning group meeting was held at Savar, brining together a handful of the people who had been involved in the organising process. That meeting helped to elaborate ideas of the type of organic structure that could take the People's Health Movement forward. For those present, walking through the great hall where less than a year before 1500 people had been there was a moving experience. Strangely silent now, but still the echoes of the voices could be heard, the memories of the moments could be felt and the power of the people's strength could still be felt.

Appendix 9: Communication matters!

Developing a communication strategy within the People's Health Movement

The People's Health Movement (PHM) grew out of the process to hold a People's Health Assembly (PHA) in Bangladesh in December 2000. During the 18 months leading up to the PHA, a strong and sophisticated communication strategy and process was in place.

It involved making use of a range of communication media – paper, electronic, visual, face to face – to spread the word about the forthcoming event, to solicit support, to encourage participation, to disseminate a range of materials for discussion, to create foras and spaces where dialogue could occur.

This strategy helped to mobilise people around the world to hold local events, work collectively on developing materials, including the People's Charter for Health, translate materials, organise events and processes to feed ideas and issues into the main meeting, collect evidence and testimonies, and develop and share advocacy positions.

In stark contrast, the two and one-half years since the PHA has been characterised by a lack of a clear communication strategy on the part of the PHM. Few materials have been developed. Strategic opportunities have been missed. Regular dialogue with participants in the movement has not occurred. Consistent targeting of key audiences, particularly policy makers, has not happened. Even the effective use of vehicles controlled by the PHM – its website, its regular news brief, and its electronic e-mail discussion list (PHA-Exchange) has not been optimal.

If the PHM is to maximise its impact on the global stage and to continue to stimulate local action, social mobilisation and organisation, it will need to pay more attention to its communication approaches in the future.

Communication challenges

The PHM has a range of audiences that it needs to communicate with. Three broad audiences that are essential to dialogue with are:

- people and organisations at the grassroots
- active and passive friends (including participants in the Movement) and a wide variety of NGOs active in health and related development fields
- decision makers at various levels.

(There are other audiences, including: educators, trade unions, political leaders (who are also decision makers, but a special type), donors, and the media. Each of these and each of the three key audiences could be split into a variety of sub-groups.)

The PHM has a range of communication tools, channels or media that it can use, some more developed than others. These tools include:

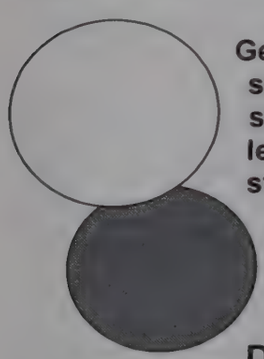
Medium	Who does it reach?		
	Grassroots	Friends	Decision makers
Mass media		✓ (regionally)	(✓)
Newsletter		✓	✓
Website		(✓)	✓
E-mail/listserver		(✓)	
Charter		✓	✓
Active campaigns/word of mouth	✓	✓	✓
Meetings/workshops	✓	✓	(✓)
Video	(✓)	✓	
Performing arts	✓		

The tools or channels that are most effective at reaching grassroots organisations are those that are the most face-to-face, the most time consuming and in many ways the most resource intensive. Those are, however, also the tools that are the most interactive, the most two-way and the tools that most enable the stories and the voices of the unheard to be heard.

This sets up a challenge for the PHM around how to deal effectively with what are essentially two communication objectives:

- the need to grow and sustain the movement
- the need to achieve change.

The communication challenge for the PHM is to balance these twin tracks. Each track, each objective requires dedicated communication strategies. However, these strategies need to be interlinked:



Generating the communication around advocacy for change without simultaneously supporting the communication around growing and strengthening the movement will lead to a weakened campaign, and less likelihood of change occurring. Focusing on communication to strengthen the movement without a clear definition of why the movement is developing and what change it is seeking, will lead to disempowerment and a decline in interest in being part of the movement. One without the other will not work.

Developing a communication strategy

There are seven basic questions that need to be answered in developing a communication strategy. These are set out in the table below, together with a number of additional questions that explore in more detail how to proceed on a particular aspect of communication.

Who?	What **audience**(s) are we trying to reach? What do we know about them and their understanding, their information needs and their preferences? What secondary audiences are we also trying to reach?
Why?	What **purpose** do we have in mind? What are we trying to achieve? What do we want the audience(s) to do? What are our objectives?
What?	What information or messages – what **content** – do we want to convey in order to achieve our objectives and to motivate and mobilise the audience(s)?
How?	What communication channels or **media** will be most effective in doing this? What combination of channels will work best?
When?	What critical **timing** is involved? Are there key windows of opportunity? Are there key dates by which something needs to happen?
Where?	In what **settings** will our communication be used? Do we need to adapt our approach for different settings?
What's happening?	Is the communication working? Is it achieving what we hoped it would? What **feedback** are we getting from our audience(s)? How can we improve the feedback to ensure that the communication works more effectively?

Communication strategies need to be reviewed regularly. Circumstances change; objectives change; audiences change.

The main reason for developing a communication strategy is that it moves attention away from communication **products** (leaflets, posters, booklets, discussion lists, websites, videos, workshops, events) to communication **processes** (how interacting, networking, involving, participating, encouraging, enhancing, empowering can best be achieved).

Getting communication flowing

Over the past year or so, the only audience that has been consistently reached by the PHM is the media, through a series of media releases. However, even this could be more effective. Having a clear purpose for the news releases – recruiting new participants, changing a specific policy, raising awareness on a particular issue, mobilising support for a campaign – could have strengthened the media work and made it more cohesive. Equally having a standard media pack available – something with a clear description of what the PHM is, what it does, what it stands for, who is involved and how to reach them – would help to encourage greater media interaction.

Over the past year, the website has been reconstructed, brought up to date, and improved. However, a targeted campaign to drive people to the site, to make it the main point of call for those who have electronic access and are interested in primary health care and a coherent analysis of the impact of social, economic and political determinants on health, has not been carried out. Nor has a plan been put in place to keep the site up to date and to make it more than simply a repository or archive of historical material.

The two most regular public communication vehicles for the PHM - its NewsBrief and the electronic e-mail discussion list, PHA-Exchange – both need to be assessed and revitalised.

Who is the NewsBrief aimed at? What type of information does it convey? Does it stimulate involvement in the Movement? Does it provide a campaigning focus?

Who does the e-mail list target? What does it aim to do? Is it a guide to PHM policy or merely an open discussion forum?

Clarifying these questions would help to turn both these vehicles into powerful and proactive communication tools.

A key example of a missed opportunity comes from the recent activity around the World Health Assembly in Geneva in May 2003. Some fifty people from the Movement were in Geneva. However, it was not clear from any of the internal or external communication material, what was the purpose of people being in Geneva. Was it to lobby the Assembly to try to achieve some gains on particular agenda points? Was it to hold a major conference on key global health issues? Was it to engage in dialogue with key decision makers at WHO, other international bodies and ministries of health? Was it to build and develop the Movement?

With no prepared policy documents, no clear position statements, and no coordinated pressure coming from national activities, it is difficult to see what significant impact could be realised and what lasting impact could be sustained. Again, the only strategic planning around communication went into the media work, where high visibility was stimulated. However, a media campaign without strong substance underpinning it will not sustain a movement, a network, an organisation, a campaign.

The latest issue of the news brief (number 9) which came out dated May 2003 is still described as the People's Health Assembly, not the Movement. It had no mention of the position that PHM was taking at the WHA – a missed opportunity. It did not reflect the international strength of the movement. It had no call for action. This was a communication opportunity that was missed.

The PHM cannot afford to miss such opportunities. It needs a clear direction for its communication work, and it needs dedicated staff working on communication issues.

PHA Secretariat, Savar
December 3rd 2001

Dear Friends of the People's Health Movement

We are very pleased to be able to share with you the agreed plan to enable the development and strengthening of the People's Health Movement. We believe that it provides the foundation for our People's Health Movement.

The proposals that were developed at a meeting in Savar in October have now benefited from wide consultation receiving many comments. We have received many important contributions and wherever possible these have been incorporated. We are very happy to say that all the comments we received were very positive about the new structure and comments focused on clarifying and strengthening the new structure. Many people went on to suggest where and how they wanted to be involved and how to enable more people to be involved. The positive responses have been very inspiring.

Summary of the proposal

The structure will enable places and spaces for all who wish to be part of the People's Health Movement. At the same time we believe that this will enable the People's Health Movement to be inclusive and transparent, democratic and open. In summary, the proposal is to develop a series of linked circles. These will be of two types. First, Geographical Circles at national, regional and international levels. Second, Working Circles for areas of work and activity of the People's Health Movement. These could range from policy and lobbying issues such as one bringing people and their organizations together to work on issues and lobbying related to PRSPs or Rational Drugs to the work of the movement through Publications or Popular Communications. The circles and how they link are outlined in detail below.

Background

A year ago nearly 1,500 people from 93 countries came together in the Gonoshasthaya Kendra center at Savar to celebrate the first People's Health Assembly (PHA2000). This historic event was the result of a worldwide pre-assembly process involving tens of thousands of people. Why?

In 1978 representatives of the world's governments committed themselves to Health for All by the year 2000. The year 2000 came and the enormous distance that millions of women, men and children were away from that right was a terrible indictment of governments and international institutions. It was, and is, also a clear and tragic expression of the unjust and unequal world that we live in today. The people and their organizations across the world that are building a People's Health Movement believe that this must change and that we must enable a movement to advocate for and pressure for health rights and generate credible people-centered alternatives to existing approaches to health.

Here we share with you: -

1. The new structure for the People's Health Movement
2. The timetable for the taking forward of the new structure

We believe that this new structure is crucial as we move towards developing a vibrant People's Health Movement. You are part of this movement and believe that the new structure will give a space and place for you and more people and their organizations to join together in the People's Health Movement.

Thank you

Yours sincerely

Dr. Qasem Chowdhury
PHA Co-ordinator

BUILDING OF PHA2000

The People's Charter for Health

The People`s Charter for Health that emerged at the end of the Peoples Health Assembly 2000 (PHA2000) at Gonoshasthaya Kendra, Savar, Bangladesh on 8th December 2000 is an important landmark, perhaps as significant as the Alma Ata Declaration. It is now an important instrument for advocating the Health for All - goal. Its significance has at least three if not more components:

Firstly, it arose out of a mobilization and preparatory process for the PHA2000which took place all over the world – culminating as a document that was ratified by nearly 1,500 members of Civil Society from 93 countries. It therefore represents the largest consensus document on the current health situation and the challenges.

Secondly, it provides both an analysis of problems and causes as well as 'perspectives for action'. Health is not just bio-medical but has an economic, political, socio-cultural and environmental dimension as well. It highlights the point that Health Action must involve action at all these levels so that the deeper determinants of health are tackled. It also challenges the vertical, top-down, market economy determined, programmes of 'magic bullet' prescriptions as not being representative of comprehensive primary health care approach which was at the core of the means to achieve the Health for All goal.

Thirdly, the charter also emphasizes in a more indirect way that the mainstream of health – including health ministries and health departments of national governments, international agencies like WHO, UNICEF, World Bank and the corporates have conveniently largely ignored the Health for All goal and sidelined it.

Challenging the mainstream

The challenge for the Post – PHA2000 initiatives is therefore to bring back the People's Charter for Health into the mainstream of health action. This can be done by advocating it in a strategy that challenges the mainstream to respond to it and integrate it within their evolving agenda. So, advocating the People's Charter for Health actively, consistently, collectively in as many forums, meetings, workshops and also institutions, networks, at local, state, national regional and international levels should therefore be a primary concern till we get it into mainstream thinking on health.

PREPARATORY PHASE, WHICH WE ARE IN AT PRESENT

Building collective consensus

Building further collective consensus on People's Charter for Health within Civil Society should continue to be the first step in every country and region. The pre-PHA2000 mobilization phase took shape in different ways and at with different levels of intensity in different regions, and countries of the world. Though 93 countries finally participated at the event, the participants from these 93 countries did not always represent or bring with them a broader consensus from their own region or country. In some cases there were individuals representing countries; in others there

were NGOs representing some mobilization in Civil Society; in some countries and regions there were more collective efforts; like India where there were very intensive efforts to organize. All were seeds for the future of the People's Health Movement.

There is urgent need to continue this process of consensus building, to strengthen the civil society consensus and endorsement of the People's Charter for Health in each country, region and globally.

Some key issues in developing and strengthening the People's Health Movement

a) Developing a core circle of individuals willing to give time to People's Health Movement
b) Focusing on Networks / Membership organizations and not just individuals or NGOs. We are a movement and not an NGO.
c) Ensuring as far as possible collective, democratic decision making, so that all constituents have opportunity to contribute, participate, suggest and facilitate the work of the People's Health Movement. The organizational framework should be circular and not pyramidal.
d) Respecting the autonomy of each participating network to do other activities in the People's Health Movement spirit.
e) Maintaining good communications between circles, countries and regions through regular email communication, newsletter, website etc.
f) Producing 'consensus' documentation authored collectively and not by individuals so that ownership of ideas and perspectives is enhanced and collectivized.
g) Strengthening instruments for advocacy

2. WHERE DO WE WANT TO GET TO BY 2005?

- To generate credible people-centered alternatives to existing approaches to health.

- To enable a movement to advocate for and pressure for health rights.

- **The People's Charter for Health should be a guiding document both for the People's Health Movement, for a growing number of national governments (not just Ministries of Health) and parts of the UN institutions i.e. the WHO, UNICEF, UNFPA, UNDP etc.**

- **People and their movements to be enabled to popularize and use the People's Charter for Health and to develop and lobby for local and national level alternatives.**

- **By 2005 the People's Charter for Health should be 'on the table' and, it and related documents which share positive people-centered practice, should be seen as credible alternatives.**

- **That the movement is recognized as the People's Health Movement as opposed to the People's Health Assembly**

- For the People's Health Movement to take root so that international bodies such as the WHO, WTO, UNICEF, World Bank, listen to the People's Health Movement.
  This could be achieved by;
  - **the weight of the presentation of our strategies for alternatives and exposing the gap between rhetoric and reality.**
  - **collective pressure**
  - **the perceived weight and presence of the People's Health Movement**

- **Development of specific strategies and actions with respect to national governments. These would be focused on national level health and related policies and practices and on highlighting the current and potential role of national government on international bodies such as the WHO, WTO and World Bank. The People's Health Movement should contribute to the demystification of the WHO and World Bank etc. and demand national-level accountability.**

- **We will have developed documents that present key principles and people-centered and community based practices.**

- **To have held a series of Regional People's Health Movement Circle assemblies during 2003-2004**

- **We will decide if a second People's Health Assembly, PHA2, will take place. If there is a positive decision, we will also decide when and where. By January 2005 we will have reviewed the People's Charter for Health.**

A People's Web

Towards Structures

for

A People's Health Movement

Agreed
December 2001

TOWARDS FACILITATING STRUCTURES FOR A PEOPLE'S HEALTH MOVEMENT

Principles

- Develop a feeling of belonging to a movement for change.
- Inclusive. We will enable people and organisations with different and diverse backgrounds to be part of the PHM. However we will ensure that a pro-people orientation remains fundamental. (This will sometimes require positive action i.e. for people with disabilities)
- Transparent, democratic and open
- Representative of
  - South/North
  - Genders
  - Ethnicity/Race
  - Emailing and without access to email
  - Different languages as possible
  - Ages/Generations - especially young and older people
- We need to celebrate diversity and encourage and recognize that there are multiple solutions.
- We recognize that Women's access to health often is still unequal and inappropriate and that this needs to be challenged and changed.
- Linking with networks and movements, being complimentary to the work of others and providing a space for others. The PHM places importance on membership organisations, networks and movements with democratic decision making processes. This is key.
- Work based and building on the People's Charter for Health. This is our fundamental common ground.
- Build on collective energies and actions
- Each country in their own way

Assumptions

1. There is a need for a global structure and that this has to be founded, informed and inspired by people's experiences, strategies and visions.

2. The base should be geographical, building on our strengths. The regions of the world should suit us.

3. Our structure should bring together organizations and movements and facilitate exchanges of experiences, information, strategies and actions between them.

4. The focus is not on decision making though this is of course needed

5. The type of organizational structure most appropriate to the development and strengthening of the People's Health Movement is not pyramid shaped but circular.

THE NEW STRUCTURE

Circles

The **Circles** are the foundation of our structures.

Circles are created and made up of people who are representatives and activists from organizations and are people committed to working on the issue or activity that is the focus of the circle.

Circles are open and not closed.

Circles can have autonomy to agree on their most appropriate ways of working.

Circles should develop and agree plans for their work and share these as appropriate.

Circles will intersect.

Circles, when formed, will elect a link person(s) to link to other appropriate circles.

Types of circles

Circles are envisaged at different **geographical** levels and for different areas of work – **Working Circles.**

Geographical Circles are envisaged at a minimum of three levels

1. National People's Health Movement Circles
2. Regional People's Health Movement Circles
3. International People's Health Movement Circles

Different areas of work can generate different **Working Circles**. These are also envisaged to exist at the three geographical levels when appropriate. Some may first be established at the international level. As activity and interest is developed then connected regional and or national circles might be developed.

A member of a working circle would come from and be on a national or regional circle. They would be the link person for that area of work or activity on their circle.

Members of working circles have the obligation and responsibility to share their work with other members of their national or regional circle.

Linking of Circles

One of the most important parts of the structure is the way in which circles link together. Elected members of each circle will be the link person to other appropriate circles. This could be between two different working circles or between a working and geographical circle. The linking has many roles and responsibilities. It is key to enabling the People's Health Movement to be more comprehensive and to making sure that the geographic and working circles share their ideas and activities. The links can also enable us to join and co-operate with other movements and networks.

Many individuals and organisations involved in the PHM across the world are already involved in specific advocacy work. The PHM aims not only to generate credible people centred alternatives but also to recognise, collate and endorse such alternatives that emerged before and after the People's Health Assembly 2000 and that will emerge in the future. Some are linked to the PHM and others are independent. The new structure ensures that they have a place for this to continue, to be able to share this better with other activists and to link with other people and organisations engaged in complementary activity.

Geographical Regions

The **initial regions** are based on areas where the People's Health Movement has some strength with two exceptions. These are West Africa and China, where we plan to have some strength in due course.

The initial regions proposed are;

1. India
2. South Asia, not including India
3. South-East and East Asia, not including China
4. China
5. Pacific, Australia and New Zealand
6. Middle East and North Africa
7. West Africa
8. East and Central Africa
9. Southern Africa
10. Europe
11. South America
12. Central America including Mexico and the Caribbean
13. North America

This is not a complete or perfect regionalization of the world and through discussion, consultation and evolution we will be able to evolve a regionalization which reflects what each region feels is a viable and a positive contribution to the People's Health Movement. National Circles would need to decide on what is the most suitable and appropriate region for them.

Some countries may feel it necessary and appropriate to establish regional, province or state level circles.

National circles would elect link person(s) with a Regional People's Health Movement Circle.
One elected representative from each of these Regional People's Health Movement Circles will be a representative for the International People's Health Movement Circle.

Secretariat

It is proposed that there is a Secretariat for the International People's Health Movement. The Secretariat will play an important role in catalysing and facilitating the different circles and their inter-relationships. The Secretariat is likely to rotate after an agreed period if this was felt to be desirable and feasible. It is expected that the Secretariat will move every few years. It would not be permanently in one place. The role and functions of the Secretariat would need to be agreed.

International People's Health Movement Circle

The International People's Health Movement Circle will be the reference body for the

Secretariat.

It is also proposed that the co-ordinator or facilitator of the Secretariat for the International People's Health Movement will be representative on the International People's Health Movement Circle. This will mean that the initially the International People's Health Movement Circle has a minimum of fourteen members.

It will be the right of the International People's Health Movement Circle to increase this if appropriate.

Ways of working would be agreed for the International People's Health Movement Circle.

It may be desirable for the for the International People's Health Circle to elect a smaller group who would be a reference group for the secretariat on certain agreed issues.

Working Circles

a) Working Circles- to enable the development and strengthening of the PHM

Working Circles could be developed for activities that are key to the development and strengthening of the People's Health Movement itself. These will generally begin as International Working Circles.

Initially these are proposed to be a minimum of

a. People-centered communication
b. Publications
c. Communication for advocacy
d. Charter – popularizing, translating and promoting
e. Representation – Developing PHM positions and agreeing meeting attendance etc.
f. Resources, Funding and Budget
g. Developing and updating the website
h. Network liaison development
i. Relationship with and lobbying of the WHO

b) Working Circles – for policy and lobbying work

Working circles could also be developed for specific areas of policy and lobbying work. Some of these might be of a short duration and related to an activity others may be on-going. This is an open ended list. If there is the commitment and energy to establish and contribute. These might initially include

3. Health and Militarization
4. Trafficking of Women
5. Violence against Women
6. Anti-Privatization
7. PRSPs and Health
8. GATS and Health
9. Women's access to health
10. Rational drugs
11. Macro-economics and Health
12. Good examples of people-centered approaches to Primary Health Care
13. Medical Education and Health/Health Human Power Education
14. Indigenous People and Health rights

Etc. etc. etc. This list will be organic and based on people and organizations ability and commitment to do things.

Many Working Circles might be first established at the International level

In some regions for some working circles, regional circles may be appropriate and desirable.

For some working circles, national circles may be appropriate and desirable.

Each level of working circle will need a focal link person/organization as outlined above. This person/organization will be elected by the working circle. It is desirable for this role to rotate at a frequency agreed by the circle.

The International People's Health Movement Circle will need to decide on the most appropriate ways of relating to and linking with both the Working Circles- to enable the development and strengthening of the PHM and the Working Circles – for policy and lobbying work.

Specific attention will be given to the ways that the circles work and interact and outlining the principles they can work with in more detail. It may be appropriate to develop briefings on possible ways to establish and work in circles.

Developing PHM positions and responses

Position papers and documents supported by the PHM should be backed by a process of collective endorsement. Though individuals and organisations are encouraged to take public positions under their own names, a PHM position should evolve more collectively. Specific process for this will be developed by the Representation Working Circle.

Accountability and Responsibility

As stated above, a key concept in the working circles and the geographical circles is **accountability back to a constituency**. This may also be important for members of National People's Health Movement Circles as they may be there from and on behalf of certain constituencies.

The joining of these interlinked circles will create a

People's Web.

This is the end of the new structure

The timetable and process for the taking forward the new structure

From **December 2001** the agreed new structure will be taken forward.

It is proposed that initiators will be approached by the Secretariat to bring people together to establish circles. This is a very temporary role. Once initiated the members of the Circle will elect their co-ordinator and their link person to other appropriate circles. The Circle co-ordinator and link person might be the same person in some cases and different people in others. It will be up to the circle to decide what is appropriate. Circles may include a number of link people to a variety of circles.

The established circles will liaise with the Secretariat through the Link person.

The National People's Health Movement Circles. The members of the National PHM Circle will elect their co-ordinator and their link person to Regional PHM Circles and other appropriate circles. The Circle co-ordinator and link person might be the same person in some cases and different people in others. It will be up to the circle to decide what is appropriate,

The Regional People's Health Movement Circles. The members of the Regional PHM Circle will elect their co-ordinator and their link person to International PHM Circle and other appropriate circles. The Circle co-ordinator and link person might be the same person in some cases and different people in others. It will be up to the circle to decide what is appropriate

The International PHM Circle will adopt statutes to operate under when it is initiated.

Timetable

The process of establishing National PHM Circles is of course different in each country. Some already have strong national committees, others are in the process of forming them and some have limited contact with the PHM. It is proposed that National groups initiate National PHM Circles between **December 2001 and the end of March 2002.**

The National PHM Circles that are initiated by then The Secretariat will work with National groups to initiate Regional PHM Circles between **April 2002 and the end of August 2002**. Some Regional PHM Circles will be able to be initiated before this period.

It is planned for the first International PHM Circle meeting to take place by the end of **October 2002** at the latest.

Clearly new National and Regional will continue to be established and they will be able to link with established Circles as they are able.

Interim arrangements

The International PHM Circle will take over the responsibility as a reference body for the Secretariat from its initial meeting.

The Secretariat will require a reference body in the interim period. The aim is to be consistent with the proposed changes and for them to not contradict what will be developed over the next year.

As a result it is proposed to establish a **Secretariat Support Circle**. This will be composed of the elected link people in the Working Circles initiated to enable the development and strengthening of the PHM.

Initially these have been proposed to be a minimum of 9 Working Circles
- People-centered communication
- Publications
- Communication for advocacy
- Charter – popularizing, translating and promoting
- Representation – Developing PHM positions and agreeing meeting attendance etc.
- Resources, Funding and Budget
- Developing and updating the website
- Network liaison development
- Relationship with and lobbying the WHO

In electing the link people for these Working Circles people should be aware of the additional responsibility.

Other Working Circles will be expected to share their plans for work and activities with the Secretariat during this period.

As a result the Secretariat Support Circle will continue as an interim reference body.

Savar
3rd December 2001